Pain Assessment and Documentation

Quick Links to:

Site Applicability

VGH:

- T14E, T12, T9, T8, T7, T4, BPTU, CP9, CP10, PAC, Peri-Op, PAR
- T5, T6 and CCU (when PCA, Epidural & CPNB in use)
- All Medicine Units

UBCH: CSI, Surgical Short Stay, PACU, Radiology

Site applicability to expand once implementation complete

Practice Level

RN, LPN

Goal

To titrate opioids and achieve the best analgesia for each patient it is necessary to judge "how much is enough" (adequacy of analgesia) and "how much is too much" (onset of side effects) therefore the purpose of this guideline is:

- To ensure that patients are assessed and frequently reassessed for the presence of pain in accordance with the Canadian Council of Health Care Accreditation Standards (CCHAS) 1.
- To ensure that side effects that may occur as a result of pain management are identified and treated early and effectively.
- To ensure that patient's pain scores and side effects of pain management are communicated timely and effectively across disciplines.

Policy Statements

- The Pain Assessment Record must be used to document pain assessment and pain interventions in post-operative patients and when ketamine, opioid, epidural, nerve or wound infusions are used. Also when pain is complex or difficult to manage, unless the patient is documented exempt from these Standards by Palliative Care physician.
- The vital signs sheet must be used to document vital signs not accommodated on the Pain Assessment Record.
- The palliative care patient is exempt from the CPD P-075 Pain Assessment and Documentation Standards when requested by the physician.
- If the patient answers yes to at least 3 neuropathic pain symptoms OR has significant allodynia (hypersensitivity to touch + pain score > 4) the Neuropathic Pain Treatment Guidelines should be implemented.

Need to Know

- The aim of pain control is to achieve patient comfort; it is not always possible to achieve a pain score of zero and patients are often comfortable with a pain score of 0 to 3, therefore it is appropriate to ask the patient “are you comfortable?” 2
- The pain score should be the patients self-report of pain2
- To assess a patient’s pain score a number of pain scales may be used:
    - N.R.S. - numerical rating score2 - a subjective measurement of pain. Patients are asked to choose a number that relates to their pain intensity, where 0 represents no pain and 10 the worst possible pain. It is not a good measurement tool in patients who are confused or in those who have difficulty ‘visualising’ their pain.
    - Faces Scale - also a subjective measure of pain. The patient is asked to indicate which of the faces best represents their pain. A good measurement tool for patients who speak/understand a foreign language.
    - B.P.S. - Behavioural Pain Scale3 - this is an objective clinical observation tool used for patients unable to provide a self-report of pain or is non-verbal. A good measurement tool when patients have dementia however ‘other’ tools are available for use in the non-verbal patient4.

- The use of pain assessment and documentation assists with:
    - Deciding on appropriate pain intervention
    - Indicating a change in the patient’s condition
    - Informing health carers of quality of patient care
    - Prioritizing patient care

- Regular observation for side effects of opioid; nausea, vomiting, constipation, pruritus and urinary retention must also occur.

Protocol

- Ensure the patient understands the importance of assessment for pain and the side effects of pain management.
- Assess pain and other vital signs on admission to the unit.
- Re-assess for pain intensity, neuropathic pain symptoms and monitor the use of the pain modality as per the Pain Assessment and Documentation Standards[2]. The patient should never be woken to have their pain assessed.
- Patients pain should be assessed at rest as well as during movement/activity2

The sedation score must be used to monitor for respiratory sedation since a decrease in respiratory rate has been found to be a late and unreliable indicator of respiratory depression and pulse oximetry may be a poor indicator of respiratory function if the patient is receiving supplemental oxygen2. Use the Guidelines for Assessing Sedation and Respiration during Opioid Therapy.

Documentation

VGH is currently transitioning to the new Pain Assessment Record; thus units with new Pain Assessment Record will assess for pain and document findings as per the Pain Assessment and Documentation Standards.

Patient / Client / Resident Education

Lack of patient education is associated with greater risk for uncontrolled pain and critical incidents. The patient must receive appropriate Pain Management Patient Information Pamphlet(s) and be informed of the following:

- Importance of identifying pain
- Potential for persistent, chronic and disabling pain if pain is not treated
- Potential for adverse reactions to the medication
- The need to report problems or adverse reaction to the nurse.
- Reinforce patient education frequently especially in the post-operative period2.

Related Documents

- Pain Assessment and Management in the Older Adult with Cognitive and/or Language Impairment

References

1. Canadian Council on Health Services Accreditation 2003.
2. Australian & New Zealand College of Anaesthetists and Faculty of Pain Medicine Acute Pain Management: Scientific Evidenced 1999, 2005. http://www.anzca.edu.au/resources/books-and-publications/acutepain.pdf
3. Campbell, M. 2000 in Acute Pain Management Measurement Toolkit (APMMT) Victorian Quality Council (VQC) 2007 www.health.vic.gov.au/qualitycouncil
4. Herr, K. et al. 2006 Pain Assessment in the Nonverbal Patient: Position Statement with Clinical Practice Recommendations. Pain Management Nursing, Vol 7, No 2 (June) pp 44-52

Revised By

CPD Developer Lead: CNS, Peri-Operative Pain Other Members: VCH Acute Pain Steering Group

(2016)

Nurse Clinician, Perioperative Pain Services

Clinical Nurse Specialist, Medicine

(2021)

Nurse Clinician, Perioperative Pain Services – Updated Pain Assessment Standards & Documentation link

Endorsed By

Medical Director Peri-operative Pain Service

Sharepoint 2nd Reading – Final for Endorsement (PSMs & affected Council Chair)

(2016)

Staff Anesthesiologist, Peri-operative Pain Service

(2021)

Staff Anesthesiologist, Peri-operative Pain Service

Professional Practice Director, Vancouver Acute

Approved for Posting

Sharepoint Final Sign-Off by Operation Directors, Vancouver - Acute Services Director Professional Practice Nursing, Vancouver

(2016)

Director, Medicine

Professional Practice Director Nursing, Vancouver Acute & Community

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Alternate Search Terms

pain assessment	lidocaine	pain assess
narcotic infusion	opioid therapy	documentation standards
Lidocaine		

Vancouver CoastalHealth

Vancouver Acute Neuropathic Pain Treatment Guidelines

Acute Pain Steering Group: Sept 2010

Patient answers **yes** to at least 3 neuropathic pain symptom items on the Pain Assessment Sheet **OR** has significant allodynia (hypersensitivity to touch + pain score ≥ 4):

If patient is on a 'pain' specialist service notify this service.
If patient is not on a 'pain specialist service' notify the attending service.

→ **Pain specialist service or Attending service will assess the patient and initiate the following:**

Spinal Cord Injury with 'at level' allodynia, notify the attending service

Post herpetic neuralgia with allodynia

Peripheral Neuropathic Pain
- painful neuropathy
- painful diabetic neuropathy
- peripheral nerve injury pain

Topical cream
Amitriptyline 2% + Ketamine 1% cream

Topical Gel
5% lidocaine ointment

Initiate the following treatment AND **refer** the patient to Complex Pain or Consult Psychiatry

Tricyclic Antidepressant (TCA) contraindicated

Arrthymia: long QT syndrome, significant conduction system (bifascicular block, trifasicular block), frequent premature ventricular contraction, sustained ventricular arrthymia
Recent MI (<6/12), unstable angina
Congestive heart failure
Orthostatic hypotension
Urinary tract obstruction
Narrow-angle glaucoma
> 65 years old (relative CI)

If there are no contraindications commence both TCA and gabapentin or pregabalin

yes →

Anticonvulsant*

Caution in renal impairment: dosage must be "renal appropriate" contact pharmacy or 'specialty' service (see over page) regarding dose in renal impairment.

Gabapentin
< 45yrs 300mg Q8H increase within 24-48hours to:
300mg QID then in 24-48hrs to
400mg QID then in 24-48hrs to
600mg QID to a maximum of 3600mg in 24hours.

45-65yrs 200mg Q8H increase every 24-48hrs to maximum of 2400mg

>65yrs 100mg Q8H increase every 24-48hrs to maximum of 2400mg

Or Pregabalin
< 45 yrs 75mg BID up to maximum of 300mg BID
45-65 yrs 25-50mg BID
> 65 yrs use gabapentin

no ↓

Tricyclic Antidepressant (SNRI)*

Nortriptyline
< 45yrs 25mg H.S. Increase by 25mg every 3 days to maximum 100mg daily

45-65yrs 20mg H.S. Increase by 20mg every 3 days to maximum 80mg daily

65yrs or with renal impairment - Caution: cognitive impairment
10mg H.S. Increase by 10mg every 3 days to maximum 50mg daily

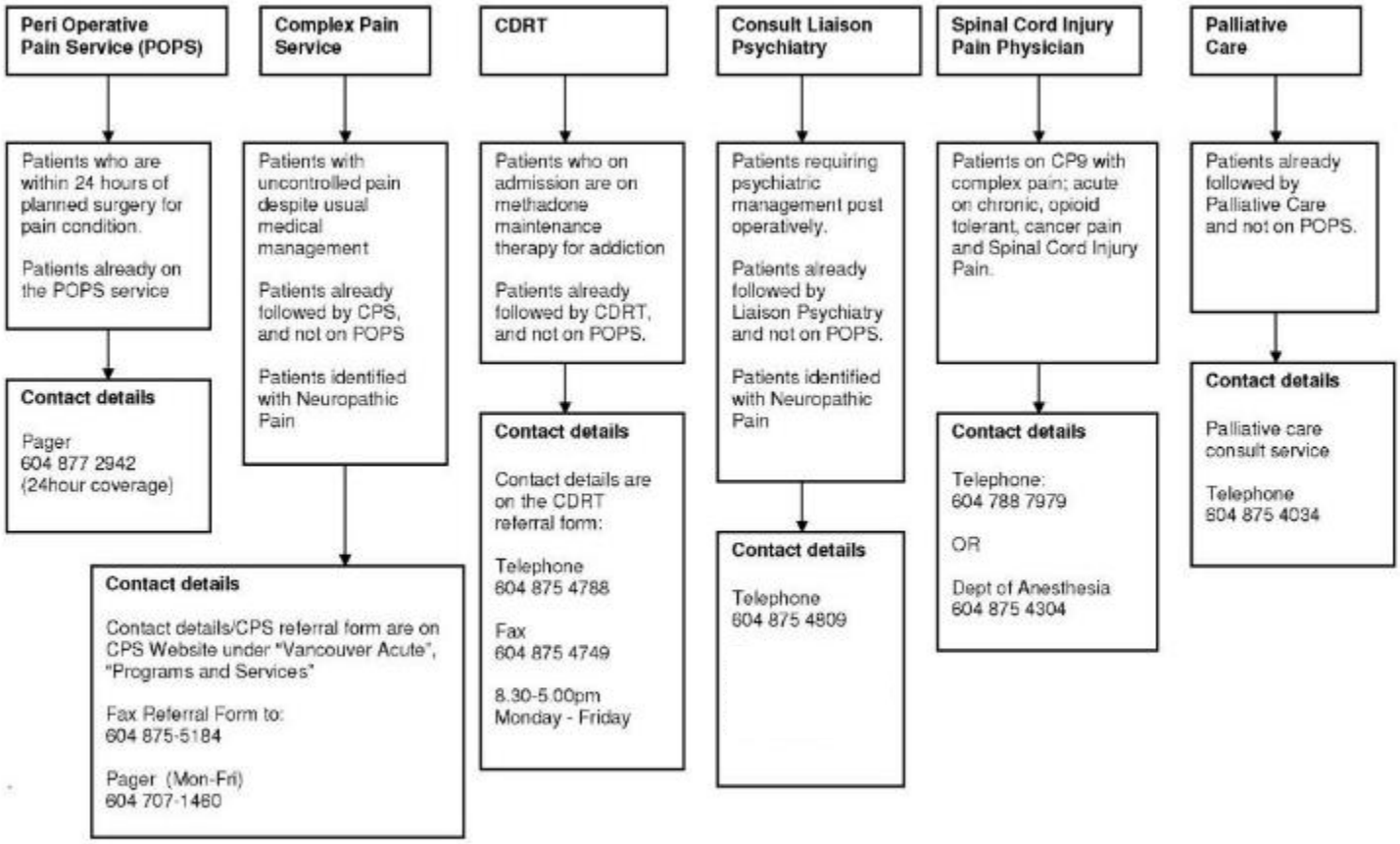
or Desipramine doses as per nortriptyline doses above

Re-assess the patient's pain prior to titration of anti-depressant or anti-convulsant.

Based on Dworkin et al *Pain* 132 (2007) 237 - 251

*Doses may exceed those stated on the algorithm when "pain specialist" prescribes

Who to call or refer your patient to when patients pain is uncontrolled



Guidelines for assessing sedation and respiration during opioid therapy

Background

Sedation precedes respiratory depression as less opioid is required to produce it. Therefore, the most effective monitoring of the patient receiving opioids is the systematic ongoing assessment for sedation. For patients taking opioid, sedation assessment is critical[1]. The goal of this guideline is to provide guidance on appropriate sedation and respiratory assessment thereby minimizing opioid induced respiratory depression. At the same time it is also important to recognize there may be other causes of decreased sedation and respiratory status such as cardiac or neurologic conditions.

Goal

The basis of the sedation assessment is to determine the amount of stimulation necessary to evoke a patient response and to score this response in a standardized and meaningful way. The respiratory assessment and SpO_2 used in conjunction with the sedation assessment provides a more complete picture of the patient condition.

The sedation and respiratory assessments must drive clinical decisions such as whether or not to:

- continue opioid use
- up titrate opioid medication
- downward titrate opioid medication
- reverse opioid treatment[1].

Policy

- The sedation and respiratory assessment must be performed prior to opioid use.
- The Pain Assessment and Documentation Standards guide the frequency of sedation and respiratory assessment.
- The Registered Nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression as per order.
- The following Pasero Opioid-Induced Sedation Score (POSS) should be used for conducting a sedation assessment:

Protocol

Sedation Score

Pasero Opioid-Induced Sedation Scale (POSS)[3]		
Score	**Meaning of Score**	
S	Sleep, easy to rouse	**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 roused	**Acceptable**; no action necessary; may increase opioid dose if needed
3	Frequently drowsy, rousable, drifts off to sleep during conversation	**Unacceptable;** • remove PCA button if in use, hold next oral dose of opioid **and** NOTIFY prescriber /POPS for adjustment of opioid orders • monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory • consider administering a non-sedating, non-opioid analgesic for pain i.e. acetaminophen or NSAID
4	Somnolent, minimal or no response to verbal and physical stimulation (use trapezius muscle squeeze for physical stimulation - do not use sternal rub)	**Unacceptable;** • stop opioid • oxygen by mask 10L/min and monitor vital signs • administer naloxone as per order • IMMEDIATELY page Prescribing Service STAT • **PROVIDE AIRWAY and BREATHING SUPPORT** • **DO NOT re-commence opioid therapy prior to patient being seen by the prescribing service physician**

Respiratory Assessment

Monitoring of a patient's respiratory status with ongoing sedation assessment is critical to detecting respiratory depression in opioid-sedated patients on PCA or regular opioid [4,5]. The respiratory rate **and** quality of respirations will be included in a respiratory assessment, as follows:

Respiratory Rate

The respiratory rate must be counted for 30 seconds, however if the respiratory rate is less than 12/minute the rate must be counted for a full minute. The respiratory **rate** and the **quality** of respirations vary a lot and are important in determining the effectiveness of breathing. The following table should be used for conducting respiratory assessment:

Respiratory Assessment		
	Breathing effective	**Breathing ineffective**
Upper Airway Sounds	*Patent upper airway* Normal sounds	*Partial obstructed upper airway* snoring, gurgling, stridor, wheezing sounds
Rhythm	Regular, no apnea	Irregular, apneic periods
Depth	Chest expansion 'normal' and symmetric, air entry audible to bases	Decreased chest wall movement, diminished air entry
Work of breathing	Easy	Use of accessory muscle, nasal flaring, tracheal tug, retractions, paradoxical respirations
Colour	No peripheral or central cyanosis or pallor	Central and/or peripheral cyanosis
	⇩	⇩
Rate > 10 and sedation score ≤2	Acceptable	Unacceptable • Stop opioid therapy • Remove PCA button if in use • Oxygen therapy • Manage airway • Call CCOT • Notify opioid prescriber
Rate 8-10 and sedation score ≤2	Acceptable • Consider decreasing opioid by 50% • Consider removing PCA button if in use • Notify opioid prescriber	Unacceptable • Stop opioid therapy • Remove PCA button if in use • Oxygen therapy • Manage airway • Call CCOT • Notify opioid prescriber
Rate ≤ 8	Unacceptable • Stop opioid therapy • Remove PCA button if in use • Oxygen therapy • Manage airway • Administer naloxone if prescribed • Call CCOT • Notify opioid prescriber	Unacceptable • Stop opioid therapy • Remove PCA button if in use • Oxygen therapy • Manage airway, • Administer naloxone if prescribed • Call CCOT • Notify opioid prescriber

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1. Toolkit Patient Controlled Analgesia (PCA) Guidelines of Care. San Diego Task Force December 2008 http://www.hasdic.org/documents/Tool-Kit-PCA.pdf
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