Annual Pain Competency

2016

Revised for RBMC

Please call Professional Development at X4196 or X5947 if you have any questions

Hackensack Meridian Health
Objectives

The learner will be able to:

• Explain pain scales & appropriate use of each
• Identify the components of pain assessment including documentation as per the RBMC assessment policy.
• Describe what a Functional Pain Goal is AND how to establish a goal.
• Explain baseline assessment prior to starting PCA, monitoring parameters & documentation.
• Explain Pasero Opioid Induced Sedation Scale (POSS) & when to call rapid response.
• Describe patient & family education with documentation.
Numeric Pain Scale
Adults and Children

• Use in all patient care settings for patients who are able to use numbers to rate the intensity of their pain.

Score:
• 0 = No Pain
• 1 – 3 = Mild pain
• 4 – 6 = Moderate pain
• 7 – 10 = Severe pain

This is the most accurate Scale!
Wong Baker Faces (Self Rating Scale)
**FLACC**

Used to assess pain in children greater than 2 months and adults who are unable to give a self-report.

<table>
<thead>
<tr>
<th></th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
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<tbody>
<tr>
<td>Face</td>
<td>No particular expression or smile</td>
<td>Occasional grimace or frown, withdrawn, uninterested</td>
<td>Frequent to constant quivering chin, clenched jaw</td>
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<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking, or legs drawn up</td>
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<td>Activity</td>
<td>Lying quietly, normal position, moves easily</td>
<td>Squirming, shifting, back and forth, tense</td>
<td>Arched, rigid or jerking</td>
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<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimpers; occasional complaint</td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
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<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging or being talked to, distractible</td>
<td>Difficult to console or comfort</td>
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</table>
Neonatal Infant Pain Scale (NIPS) Used for Infants

0 – Relaxed muscles Restful face, neutral expression
1 – Grimace Tight facial muscles, furrowed brow, chin, jaw

Cry
0 – No cry Quiet
1 – Whimper Intermittent mild moaning
2 – Vigorous cry Loud scream; continuous shrill crying
(Note: A silent cry may be scored if the baby is intubated, but crying is evidenced by facial movement.)

Breathing pattern
0 – Relaxed Usual pattern for the individual baby
1 – Change in breathing Retractions, irregular respirations, tachypnea, gagging, breath holding

Arms
0 – Relaxed No muscular rigidity, occasional random movements
1 – Flexed/Extended Tense straight arms, rigid and/or rapid extension/flexion

Legs
0 – Relaxed No muscular rigidity, occasional random movements
1 – Flexed/Extended Tense straight legs, rigid and/or rapid extension/flexion

State of arousal
0 – Sleeping/ Awake Quiet, peaceful, sleeping or alert and settled
1 – Fussy Alert, restless, thrashing
When is pain assessed?

• What does the policy state?
Pain Assessment & Reassessment

All patients will be assessed for pain and documented:

• upon admission
• every shift
• during and after procedures known to be painful
• when pain is reported
• according to the patient’s needs.
• until an acceptable level of pain relief and/or pain goal is achieved.

Reassessment is completed and documented:

• after 15 minutes and 60 minutes for IV medication
• after 30 minutes for IM medication
• after 60 minutes for oral medication or complementary intervention
Pain Assessment & Reassessment

Reassessment parameters include

- B/P
- RR
- Pain Score
- Pulse Oximetry
- Pasero Opioid Sedation Score
Why do we ask for an acceptable level of pain?

- Purpose: to identify how much pain can exist without interfering with the function and quality of life
- Reason for using pain rating scales—evaluate the effectiveness of intervention
- To do this we must set goals
- What level of pain may be noticeable but not bothersome?
- Research strongly suggests that pain rating goals of 4 or more on a 1-to-10 scale are not appropriate.
Why do we ask for an acceptable level of pain?

• In order to avoid over sedation or other undesirable side effects of pain medication it is very difficult to meet a pain score of 0. Therefore, it is not helpful to simply ask a patient, “On a scale of 0-10, what is your pain goal?” as most patients would probably say “0”.

• When establishing a pain goal/acceptable level with the patient it is more helpful to say, “It is not always possible to eliminate all pain, but our goal is to reduce your pain to a reasonable or comfortable level” or “At what number do you think you will be comfortable or will be able to walk, rest, or do necessary activities?”
  • Ask your patient:
    – “How are we doing with managing your pain?”
    – “What do you find helps to relieve your pain?”
Tell patients: “I am doing everything I can to help relieve your pain.” i.e., Raising the head of your bed/turning you on your side to make you more comfortable/help relieve your pain.”
Setting Realistic Goals & Expectations

Have a conversation with the patient:

• What are the patients’ expectations
• Are the expectations achievable
• Discuss likely and unlikely outcomes
• What medication is ordered
• How often the medication can be given
• Set realistic goals
• Communicate what you are doing to help control the pain i.e. “I called the Doctor”, “I am waiting for a call back”, “I am getting your pain medication now”. 
Creating a Patient Centered Pain-Function Goal

Other Things That Can Be Said To the Patient:

1. “Pain medicine can make you very sleepy and may affect your breathing. We will work with you to keep you safe and help you be as comfortable as possible.”

2. “Your pain needs to be low enough so you can walk, rest, and do any required activities.”

3. “Good pain control should also allow you to get some rest without getting too sleepy.”
Fentanyl Patch
Tips and Safety Info

APPLICATION OF THE PATCH

1. Do not use soaps, oils, lotions, or alcohols on the skin prior to administration as this may irritate the skin.
2. Each patch needs to be pressed down for 30 seconds for the adhesive to stick.
3. Do not cut or alter the patch in any way.
4. The patch is intended to remain on for 72 hours, but does not reach its peak concentration until approximately 20 hours after application.
5. After the removal of the 1st patch, a 2nd patch may be applied, but only to a different area of the body than the 1st patch.
6. Ensure that newly admitted patients do not have a pre-existing patch on before applying one.
Fentanyl Patch Tips and Safety Info

**MONITORING**

- Any signs or symptoms of respiratory depression or sedation
- Observe the patch to ensure it is still intact after application
- Check the patch after a patient returns from any procedure, ie. dialysis, imaging, etc. to insure the patch is still in place
- If the patient develops a **fever of 102°F or greater**, contact prescriber. Dose reduction maybe required.

**PATCH WASTING**

1. Education on the process to document the discard of the patch is forthcoming. The process has not yet been finalized.
2. Once the patch has been removed from the patient fold the patch in half so the adhesive sticks together
3. Flush the patch down the toilet
Patient/Family Education

Teach the patient:

- How to use the pain scale.
- Establishing a pain goal
- How the PCA works i.e. drug, dose, delay, hourly limit
- How to push the button on the PCA
- Notify the nurse if pain is not controlled or if feeling sedated
- How often the medication can be received
- Side effects of the medication
- The onset and duration of action of drug

Document Education in the Patient Education section of the Electronic Health Record

Evaluate the effectiveness of the education provided & document
Important Points

• In addition to the required shift assessment, assessment and reassessment is to be done for each report of pain.

• Communicate with the patient what would be a realistic level of pain
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<tr>
<th>DATE/ TIME</th>
<th>Delivered</th>
<th>Total Drug</th>
<th>Continuous Infusion</th>
<th>PCA Dose</th>
<th>RESP.</th>
<th>BP</th>
<th>PULSE</th>
<th>SpO2</th>
<th>ETCO2</th>
<th>COMMENTS/RN SIGNATURE</th>
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11P-7A total

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7A-3P total
# The PCA Flow Sheet-Back

**Review Pasero Opioid Induced Sedation Scale and Monitoring Parameters**

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**PASERO OPIOID - INDUCED SEDATION SCALE (POSS)**

- **S** = Sleep, easy to arouse (no action necessary)
- **1** = Awake and alert (no action necessary)
- **2** = Slightly drowsy, easy to arouse (no action necessary)
- **3** = Frequently drowsy, arousable, drifts off to sleep during conversation (notify MD)
- **4** = Somnolent, minimal or no response to verbal and physical stimulation (stop infusion and call RRT)

**CONTINUOUS OPIOID INFUSION MONITORING:**

- Every one hour x 4 hours at initiation of IV Analgesia
  - Blood Pressure
  - Heart Rate
  - Respiratory Rate
  - Pain/ Sedation Level

**THEN**

- Every 2 hours x 12 hours
  - Respiratory Rate
  - Pain/ Sedation Level

**THEN**

- Every 4 hours for duration of IV Analgesia
  - Respiratory Rate
  - Pain/ Sedation Level

**Continuous Pulse Oximetry and ETCO2 (Capnography) Monitoring and document every 2 hours**

Note: In the event of an **INCREASE** in the PCA order, the frequency of VS monitoring will revert back to the initial monitoring protocol.

**PCA ONLY MONITORING:**

- BP, HR, RR, PULSE OXIMETRY, PAIN AND SEDATION LEVEL EVERY 2 HOURS
Monitoring the Patient using PCA

Decreased oxygen saturation is a very late sign of respiratory distress & over sedation!!!

Monitor Level of Sedation!!!
Independent Check

Two RNs *Independently* verify the prescription at:

1. Syringe change
2. Prescription change
3. Initial setup
4. Change in PCA settings
5. Hand Off

**ADDITIONAL** Opioids are **NOT** to be prescribed or given for Acute pain while on PCA therapy except if prescribed by the same person who ordered the PCA.
If POSS is 4……

- Stop the opioid
- Call Rapid Response Team (RRT) or Code Blue
- Notify the prescriber (DO NOT LEAVE THE PATIENT)
- Be prepared to administer naloxone (Narcan) as ordered

Usual Administration in Adults-Requires a physician order:

Mix 0.4 mg (1 ampule) of naloxone and 10 mL of normal saline in a syringe. Administer the dilute naloxone solution IV very slowly (0.5 mL over 2 minutes) while you observe the patient’s response (titrate to effect).

The patient should open his or her eyes and talk to you within 1-2 minutes. If not, continue IV naloxone at the same rate, up to a total of 0.8 mg or 20 mL of dilute naloxone. If no response, begin looking for other causes of sedation and respiratory depression.

Discontinue the naloxone administration as soon as the patient is responsive to physical stimulation and able to take deep breaths when told to do so. Keep the syringe nearby. Another dose of naloxone may be needed as early as 30 minutes after the first dose because the duration of naloxone is shorter than the duration of most opioids.

Notify the Prescriber

- Respiratory rate less than 8
- Level of Sedation (LOS) greater than 2
- Change in respiratory pattern (Do Not Leave The Patient)
- Altered mental status
- Side Effects such as: pruritis, nausea, vomiting, constipation
- Urinary retention
Shift Totals and Wasting Narcotic

• Shift totals & hand off are verified & cosigned at the change of shift by oncoming & off going RNs in MAK

• The History is cleared after verification by both RNs

• Record on the “Controlled Substance Administration Record”. when putting a new medication syringe into the pump and when removing the empty syringe or discarding medication. Return it to the Pharmacy upon completion.
References

• Pasero, Chris MS and McCaffery, Margo MS RN FAAN (2002). “Monitoring Sedation, It’s the key to Preventing Opioid-induced Respiratory Depression. AJN, Vol. 102, No 2, p67-69.

Hackensack Meridian Health