BROUGHTON HOSPITAL
STAFF DEVELOPMENT

PAIN MANAGEMENT

SELF STUDY PACKET

INTRODUCTION

Over the past decade, enormous progress has been made in the field of pain management. Some factors impacting the pain management movement are the hospice movement, managed care, accreditation standards, research for drugs and technology, consumer education, and legislative trends.

In North Carolina, recent health regulatory agencies as well as the JCAHO have released statements and pain management guidelines. Examples of these are:

North Carolina Medical Board Position Statement
(Amended September 2008):

- Appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities. The Board realizes that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen.
- All prescribing of controlled substances must comply with applicable state and federal law.
- Guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan(contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.
- Deviation from these guidelines will be considered on an individual basis for appropriateness.

The Joint commission mandates the appointment of an interdisciplinary team for pain management and staff orientation with periodic education for pain management issues and trends. Mark Chassin, president of The Joint Commission, states, “Effective pain management is a crucial component of good healthcare, and treating pain is the responsibility of all caregivers” (Joint Commission, 2008).

To ensure compliance and accountability with current health care practices, it is in the intent of this module to orient, educate and review Broughton Hospital's pain management initiatives.

At Broughton Hospital

As part of provision of services, Broughton Hospital strives to ensure the patient's right to appropriate assessment and management of pain. From the perspective of a comprehensive service delivery system, this includes:

- Initial assessments and reassessments of pain at regular intervals as necessary.
- Provision of education to personnel who provide pain assessment and contribute to the education of patients and families, when appropriate, pertaining to this important aspect of the patient's welfare.
- In formulating an individual pain management program considers personal, cultural, spiritual and ethnic beliefs as these impact on this aspect of care.
- Includes pain management in the discharge planning process, as appropriate, to ensure the patient's health needs are met following discharge from the hospital.
- In addition to ongoing review regarding pain management, the hospital utilizes mechanisms designed to monitor the effectiveness of pain management.

DEFINITIONS

PAIN

At Broughton Hospital, pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.” “Pain is always subjective.”

ACUTE PAIN

Acute pain, which is viewed as a “complex, unpleasant experience with emotional and cognitive, as well as sensory, features that occur in response to tissue trauma.” Relatively high levels of pathology usually accompany acute pain and the pain resolves with healing of the underlying injury.”

CHRONIC PAIN

Chronic pain is pain that “extends beyond the period of healing, with levels of identified pathology that are often low and insufficient to explain the presence and/or extent of pain.” It is also persistent pain that “disrupts sleep and normal living, ceases to serve a protective function, and instead degrades health and functional capability.”

PAIN ASSESSMENT

At Broughton Hospital, patients are formally assessed for the presence of pain using the following mechanisms:

1. Psychiatric Assessment
2. Medical history and physical assessment
3. Nursing assessment

Additional assessment information may be obtained via the following mechanism:

1. Psychosocial assessment
2. Psychological assessment
3. Referrals as Indicated
4. Family members are included in the assessment process as indicated

When caring for patients who are at risk for pain the healthcare team assures that the initial assessment has been completed and that appropriate interventions have been initiated.

> **NOTE:** The health care team is constantly aware of the complications of pain and the adverse effects of pain medications such as lethargy, disorientation, constipation, respiratory depression, hypotension and decreased motility.

Obtain a set of baseline vital signs

NOTE: Increases in pulse, blood pressure and respiration from baseline are indications of pain, especially if a patient is experiencing acute pain. Those with chronic pain **may** not exhibit a change in vital signs.

Obtain a past history to include effectiveness of previously used methods for the treatment of pain and behavioral responses to pain.

NOTE: Family members will be included in the assessment process as indicated "BELIEVE THE PATIENT'S REPORT."

At Broughton Hospital, when pain is identified or is potential, an individualized interdisciplinary plan is developed to manage patients' pain. The plan is communicated with the patient and family and its effectiveness is reassessed in a routine on-going manner until the pain is relieved.

Assess the patient's level or orientation (are they able to communicate and describe pain?)

NOTE: Look at the patient – Observe the patient's behavior

MILD PAIN RATING

1) Frowning
2) Sighing
3) Reduction in Concentration
4) Gazing/Staring
5) Restlessness
6) Posture and Deviations in Voice Tone
7) Rubbing, touching, or pulling on the painful part

As pain increases in intensity, other behaviors may be observed:

MODERATE PAIN RATING

1) Increases Muscle Tension
2) Guarding
3) Limited Movement
4) Anxiety
5) Irritability
6) Decreased Concentration
7) Decreased Appetite or Overeating
8) Insomnia
9) Thrashing
10) Posturing
11) Moaning
12) Crying

If pain is not treated and reaches a severe range, the patient my exhibit these symptoms:

SEVERE PAIN RATING

1) Screaming
2) Thrashing
3) Nausea and/or vomiting
4) Sweating
5) Unable to Concentrate

Impact of Culture on Pain Management

The expression and experiences of pain are greatly influenced by culture and cannot be ignored in an ever-changing society. The mistake that many nurses make is assuming that individuals always blend into their new environment. As cultures and societies move geographically, they bring with them the aspects of their lives with which they identify themselves and find comfort. These practices at times may be in conflict with the health care team, whose mission is to help them with their health care problems (Purnell & Paulanka, 2008).

Culture refers to lifestyle, rules, and symbols that guide the behavior of a particular group of people (Racher & Annis, 2007). Culture is passed on from generation to another and within social groups through orientation and socialization. Each individual is a building block upon which cultural groups are based, thus each patient who enters the health care setting is a representation of his or her cultural group. Nurses however cannot assume that every patient within a group will have the same experience or expression of pain.

Pain is a subjective, individual experience that may not be expressed to fully convey intensity. The only person to adequately admit and describe pain is the person experiencing it. In some cultures, such as those of Arbic heritage, a woman in pain may need to ask her husband or another's male position to ask for pain medicine. In other cultures, expression of pain is minimal by males, such as the Italian and Russian cultures (Purnell & Paulanka, 2008).

NOTE: Assessments of pain and effectiveness of pain management plans are documented on formal assessments, in progress notes, flow sheets, consultations and treatment plans. Frequency of documentation is determined by the type and intensity of pain and treatment plan directives and discipline-specific medical record requirements.

PAIN ASSESSMENT SCALES

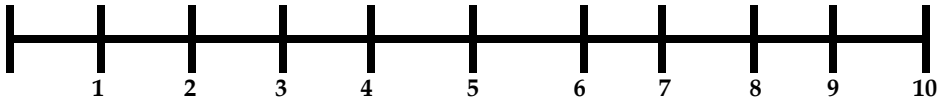
Wong Baker (Faces) Scale

Ask the patient to point to each face using words to describe their pain intensity (if able). Then ask them to point to each face that best describes their pain and record the appropriate number.

0 NO HURT | **2** HURTS A LITTLE BIT | **4** HURTS A LITTLE MORE | **6** HURTS EVEN MORE | **8** HURTS A WHOLE LOT | **10** HURTS WORST

Horizontal Number Scale

Ask the patient for a verbal response to the following question "on a scale of 0 – 10 and 10 as the 'worst possible pain', how would you rate your pain?"



No Pain — **Moderate Pain** — **Worst Possible**

NOTE: Patients who are unable to participate with pain assessments and therefore unable to self report (e.g., due to altered mental status, severe cognitive impairment, language barriers, or psychosis), are observed by staff and nonverbal signs and symptoms of pain is documented.

NOTE: At Broughton Hospital, patients involved in a pain management plan will receive education information specific to the prescribed program. Patient educational information will be documented on the Patient/Family Education Flow Record, progress notes, and/or psychosocial intervention (PSI) progress notes. Arrangements are made for continuing pain management following discharge, as indicated by the patient's needs.

- The reverse side of the Medication Administration Record (MAR) constitutes documentation of a nurse's assessment of the reason for administering prescribed PRN and single dose pain management medications and treatments, and the effectiveness of the interventions. The pain rating or observation is documented on the back of the MAR prior to administration as well as at the time of assessment of effectiveness.

MANAGEMENT OF PAIN THROUGHOUT HOSPITALIZATION

Policy Statement

Patient's rights to appropriate assessment and management of pain are ensured by providing a proactive pain management plan that is mutually established with the patient, family members (as appropriate) and members of the health care team. Patients are evaluated and screened to identify those at risk for experiencing pain. Staff receives education related to the principles of pain assessment and management.

Management of Pain throughout Hospitalization

Initial Interventions:

- **Establish** a positive relationship with patient/significant other/guardian
- **CNA's** will report and document patient's behavior or statements indicating pain is present
- **MD's, PE's, RN's** document patient assessment components and collaborate with patient/significant other and other health team members to formulate and document the pain control plan and schedule if needed (Efforts should be made to incorporate previously used effective treatment modalities whenever possible). Some suggested interventions include:

  Routine/prn medications
  Back rubs
  Reposition
  Exercise
  Pastoral visit
  Notification of physician/physician extender
  Bed rest
  Relaxation/imagery
  Distraction
  Warm/cool applications (with MD/PE order as appropriate)
  Education regarding medications or complimentary treatments

Referrals as appropriate

- **<u>Educate</u>** patient/significant other regarding his/her role in pain management, such as early staff notification of pain onset, timely communication of effectiveness of pain treatment modalities, use of designated pain scale, normal activity appropriate for age, unit routine re: pain assessment intervals, medication offerings, available non-pharmacological offerings. Emphasize importance of a factual, honest report of pain. In form patient/significant other that effective pain relief is an important part of treatment.

According to policy, patients are assessed and reassessed for pain throughout hospitalization at the following intervals:

- On Admission
- Upon transfer
- Annually
- More frequently based on their clinical presentation

The same quantitative assessment scales should be used for follow-up pain assessments.

References

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Name: _____
Date: _____
Service Area: _____

Pain Management Self Study Questions

1. Patient's have the right to appropriate assessment and management of pain.
   a) True
   b) False

2. Acute pain can be defined as:
   a) persistent pain
   b) extends beyond the period of healing
   c) occurs in response to tissue trauma
   d) pain that occurs with a terminal illness

3. Chronic pain can be defined as:
   a) pain that extends beyond the period of healing
   b) pain that disrupts sleep and normal living
   c) persistent pain
   d) all of the above

4. A through pain assessment would include the following:
   a) determination if the patient is at risk, including cultural factors
   b) obtain baseline vital signs and level of orientation
   c) obtain a pain history and baseline pain assessment
   d) all of the above

5. When a patient complains of pain, interventions might include:
   a) taking the patient's vital signs
   b) recording/reporting observations
   c) complimentary therapies
   d) all of the above

6. Which of the following may **not** be seen in a patient experiencing mild pain?

a) restlessness
b) reduction in concentration
c) thrashing
d) sighing

7. Upon a patient's report of pain or observation of related behaviors, the nurse should investigate the following:

a) Location, quality, and duration of pain
b) aggravating and relieving factors
c) Effect pain has on eating
d) all of the above

8. Which of the following may **not** be seen by a patient experiencing moderate pain?

a) guarding
b) limited movement
c) Decrease in pulse, BP and respirations
d) Irritability

9. If a patient is in severe pain they may experience nausea and/or vomiting.

a) True
b) False

10. Body language is **not** an indicator of pain.

a) True
b) False

11. Patients within the same cultural group will have the same expression of pain.

a) True
b) False

12. The following interventions may be used for all levels of pain: document a patient pain assessment, collaboration with the patient and healthcare team, initiate and document the pain control plan and reinforce patient education.

a) True
b) False

13. Patients are assessed and reassessed for pain throughout hospital on admission and:

a) upon transfer
b) annually
c) more frequently based on their clinical presentation
d) all of the above

14. The same quantitative assessment scales should be used for follow-up pain assessment.

a) True
b) False

15. Lethargy, constipation, disorientation, and/or respiratory depression are all undesired effects of pain medication.

a) True
b) False