PRINCIPLES OF HIGHLY RELIABLE CARE:
ASCENSION
PAIN MANAGEMENT
GUIDELINES
Version: 1.0

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CARE EXCELLENCE • JANUARY 2017
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Pain Management SharePoint URL:
https://communities.mymascensionhealth.org/cm/ce/PAIN-HENCFA/Pages/default.aspx

Pain Management Yammer: You can request to be added
https://www.yammer.com/ascensionexnet1/#/threads/inGroup?type=in_group&feedId=6957658

Pain Management Revision History:

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PRINCIPLES OF HIGHLY RELIABLE CARE:
ASCENSION PAIN MANAGEMENT:
EXECUTIVE SUMMARY & MINIMUM STANDARDS
The opioid addiction and death crisis has garnered the attention of national news, our nation’s leaders, healthcare leaders and the public. According to the Center for Disease Control (CDC) from 1999-2014 more than 165,000 persons died from overdose related to opioid pain medication in the United States.18

Opioids are prescribed as a treatment for pain. The CDC17 estimates that 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses receive an opioid prescription. This is enough for every adult in the United States to have a bottle of opioids. The U.S. is 5% of the world’s population but consumes 80% of the world’s opioids. Opioid-related adverse events in the hospital are also a concern. The Joint Commission44 distributed a sentinel event alert that stated of the adverse events between 2004-2011, 47% were wrong dose medication errors, 29% were related to improper monitoring of the patient and 11% related to other factors. The recommendation was for a judicious and safe prescribing and administration of opioids and the need for appropriate monitoring.

In addition to the overwhelming opioid issues mentioned above the pain dimension questions within HCAHPS are a message from our patients that we have an opportunity to improve pain management. The national benchmark rate is 78, with Ascension’s rate in 2016 being 74.7. To impact the overriding health crisis of opioid addiction and ensure a balanced pain management approach, Ascension must focus on delivering safe, compassionate and evidence-based pain management for the patients we serve across the care continuum. The principles of high reliability are the foundation used to guide this work and achieve the quadruple aim of high-quality, low-cost care through exceptional provider and patient family experience. The next two pages serve as quick reference documents to communicate the high level overall pain management strategy as well as the minimum standards. The minimum standards are derived from the specific detailed pain management guidelines. While we strive to meet all the pain management guidelines it is a process to be able to incorporate all of the recommendations. Therefore, minimum standards were identified as a place to start the journey towards full implementation of the guidelines. Minimum standards identified on the next page.

**Objective**

We are called to partner with patients and their families to deliver safe, compassionate, evidence-based pain management across the care continuum for those we are privileged to serve.

**ACTION:** Implement minimum standards across the care continuum.
Working Together to Deliver Safe, Compassionate, Evidence-based Pain Management to the Patients We Serve

Why Focus on Pain Management?

The CDC found in 2013 that more than 16,000 people died in the United States from overdose related to opioid pain relievers.

In addition, almost 2 million Americans, age 12 and older, either abused or were dependent on opioid pain relievers in 2013.

Chronic pain impacts more Americans than diabetes, heart disease, cancer and stroke.

HCAHPS Pain Dimension NATIONAL benchmark rate: 78

HCAHPS Pain Dimension ASCENSION’S 12 month rolling rate: 74.7

Ascension’s Pain Management Initiative

What: To deliver safe, compassionate, evidence-based pain management to the patients we serve, in accordance with national guidelines.

How: Develop and implement Ascension’s Pain Management Guidelines.

Ascension’s Pain Management Goals

PAIN ASSESSMENT TOOLS GOAL:
Standardize evidence-based pain assessment tools for all patient populations across the care continuum.

INTEGRATIVE THERAPY GOAL:
Increase awareness and utilization of integrative therapies as an adjunct for pain management for all patient populations across the care continuum.

PAIN MANAGEMENT GUIDELINES GOAL:
Recommend evidence-based practice solutions, in alignment with national guidelines, for the management of acute, chronic pain and hospital-based order sets across the care continuum.

Pain Management Minimum Standards

- Document pain assessment scores using the appropriate pain assessment tool for the patient.
- Access local prescription drug monitoring program prior to prescribing opioids.
- Assess opioid risk prior to prescribing opioids.
- Every inpatient must have a documented pain assessment score and acceptable level of pain within 24 hours of admission and once per day after the initial assessment.
- Do not order an X-ray, MRI and CT scan for acute low back pain without positive differentiation assessment factors.
- Order a scheduled non-opioid pharmacologic agent(s) if there are not contraindications when an opioid medication is prescribed.
- Offer patients integrative therapies solutions for pain management.
- Prescribe no more than 7-14 days of opioids when indicated for acute pain.
- Educate patient on how to dispose of unused medications.
- Ensure baseline and annual urine drug screen is obtained on chronic patients with an opioid patient agreement/contract.

For more information please contact Judy Henderson at judy.henderson@ascension.org or Tina Jacobs at tina.jacobs@ascension.org or visit the Pain Management myCommunities site at https://communities.myascensionhealth.org/cm/ce/PAIN-HENCFA/Pages/default.aspx.
PRINCIPLES OF HIGHLY RELIABLE CARE:

ASCENSION PAIN MANAGEMENT: BEST PRACTICE RECOMMENDATIONS

2a. BACKGROUND

Many organizations such as the Centers for Disease Control (CDC), American Pain Society (APS), and American Society for Pain Management Nursing (ASPMN) produced Opioid prescribing guidelines, pain management guidelines and/or position statements in 2016. Information from the media and other sources about the opioid crisis continues to dominate healthcare topics and social media.

Ascension formed System Pain Management Steering Committee, Acute, Chronic, Order Set and Primary Care Provider Pain Management Teams to design the Ascension Pain Management Best Practice Recommendations based on available evidence-based research. These teams were comprised of a variety of clinicians including but not limited to providers, advanced nurse practitioners, nurses, pharmacists, social work, and behavioral health clinicians. The clinicians practice in inpatient and outpatient settings, with adult and pediatric patients, and have specialty training in a variety of areas such as pain management, Emergency Department, senior living, home care, and primary care. The pain management best practice recommendations were reviewed and approved by the Ascension Therapeutic Affinity Group (TAG) and Care Excellence Committee (CEC).
PRINCIPLES OF HIGHLY RELIABLE CARE:
ASCENSION PAIN MANAGEMENT GUIDELINES:
BEST PRACTICE RECOMMENDATIONS

2b. SAFE AND EFFECTIVE GENERAL OPIOID PRESCRIBING GUIDELINES FOR ACUTE PAIN ACROSS THE CARE CONTINUUM

Pain management education for all providers (new and existing):

- Equianalgesic dosing/conversion charts
- General pain modules including multi-modal therapy
- Poly-sedative/pharmacy alert
- High-alert medication guidelines, such as Methadone and Suboxone
- Reversal agents

Before prescribing an opioid:

- Obtain accurate patient and medication history and allergies
  - Consider using WILDA tool\textsuperscript{20} for assessment
  - Review medication history for other sedative medications
  - If patient is currently on opioids, perform a urine drug screen
    (in outpatient setting with a patient agreement)
    □ Ensure drug screen panel includes the proper testing components
  - Identify and obtain pain management or methadone agreement, if applicable

- Check all available electronic health records (EHRs) to identify if patient has been previously prescribed opioids

- All care settings check the state controlled substance monitoring program, as this provides patient-specific information on controlled substance prescription data such as dose, quantity and ordering physician
  - Exceptions
    □ VA facilities (currently in process to be included, pending availability)
    □ Methadone for detox (from treatment center)
  - Some states must have patient name as written on a script and date of birth

- Utilize a multimodal approach by:
  - Establishing a scheduled non-opioid foundation
  - Increasing the use of integrative therapies

- Perform or obtain sedation level and pain score

- Consider pharmacogenetics testing, if available

- Provider’s office should ask patient to bring in the bottle of medication to complete a pill count

- Assess patient risk prior to prescribing
  \textit{(Section 2.F for guidelines “Assess patient risk prior to prescribing”)}
### 2b. SAFE AND EFFECTIVE GENERAL OPIOID PRESCRIBING GUIDELINES FOR ACUTE PAIN ACROSS THE CARE CONTINUUM

<table>
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<tr>
<th>If opioid prescription is necessary (applicable to all care settings):</th>
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<tr>
<td>• Transition to oral pain medications (use equianalgesic chart for conversion to oral) as soon as possible (if the patient can eat, oral can treat!). Consider timing related to discharge.</td>
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<td>• Limit quantities per CDC guidelines when transitioning to another level of care</td>
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<td>• Consider education on prevention of side effects such as constipation</td>
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<tr>
<td>• Aim for follow up visit (phone or in person) within 3-7 days per CDC guidelines</td>
</tr>
<tr>
<td>• No refills with initial prescription – if patient continues to have pain schedule another office visit to further evaluate</td>
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<tr>
<td>○ Discuss short-term use of opioids and a tapering process to avoid long-term treatment and harm with patients (during prescribing phase)</td>
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<tr>
<td>• Provider’s office:</td>
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<tr>
<td>○ Follow CDC guidelines</td>
</tr>
<tr>
<td>○ Inquire if patient is traveling to determine if multiple opioids prescriptions are necessary</td>
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<tr>
<td>• Acute care: Consider in-house outpatient pharmacy (if available) to fill and deliver prescriptions to patient prior to transition</td>
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<tr>
<td>• Consider discharge counseling by a pharmacist prior to discharge</td>
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<tr>
<td>• Prescribing options</td>
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<td>○ Electronic prescribing</td>
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<td>○ Written prescription (use tamper-resistant paper)</td>
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<tr>
<td>• Educate patient on side effects, safe storage and disposal (section 2h. - Disposal of Unused Controlled Substances recommendations)</td>
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<tr>
<td>• Communicate with primary care provider (PCP) upon transition</td>
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2b. SAFE AND EFFECTIVE GENERAL OPIOID PRESCRIBING GUIDELINES FOR ACUTE PAIN ACROSS THE CARE CONTINUUM

- Ensure pain assessments, effectiveness of interventions (pharmacologic and non-pharmacologic) and date/time of last dose given is included in handoff discussion and paperwork
- If patient has an opioid agreement, ensure this is included in handoff discussion and paperwork
- Assess patient for pain and treat as indicated prior to transition to home, senior living, and rehab facility, etc.
- Ensure discharge orders include pain medication
  - If patient is transitioning to home, follow safe and effective general opioid prescribing guidelines
  - If patient is transitioning to senior living, rehab facility or home care, ensure a prescription is available

2c. TREATMENT OF LOW BACK PAIN

Low back pain (LBP) is a common complaint that often presents in the primary care office as well as the emergency department (ED). Evidence has accumulated on the best practices in the management of LBP and the establishment of guidelines for care will help implement such practice. Acute low back pain should primarily be treated and managed in the outpatient setting. When this presenting complaint is considered without further differentiation, approximately 85% of LBP resolves within six weeks regardless of the treatment including no treatment.\textsuperscript{28,30,36}

Patient assessment:
Utilize the WILDA tool (Appendix C) to assess the patient.

Additional assessment factors to consider

- Age of patient (possibility of Osteoarthritis)
- Presence of radiculopathy
- Pain that is exacerbated by a prone position (possibility of tumor/infection)
- Any high risk circumstances for tumor or infection
  - IV drug use
  - Progressive weight loss or pre-existing carcinoma
  - Fever
- Worsening of pain by extension or flexion of spine
2c. TREATMENT OF LOW BACK PAIN, continued

Patients under the age of 70 and have none of the above factors should be managed by conservative and self-care.

- Obtain functional goal by using Motivational Interviewing techniques
- Education and reassurance: “You’re history and physical did not show anything of concern indicating a serious injury. You’re likely to recover in a few weeks. Staying active will help you recover. Imaging tests are not needed at this stage.”
- Avoidance of bed rest; light exercise as tolerated such as walking
- Consider the use of scheduled medications with proven benefits.
  - For most patients, first-line medication options are acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs).
  - Re-evaluate patient in 7-10 days. If patient is not achieving their functional goals, consider adding a non-benzodiazepine muscle relaxant as an adjunct to first-line medications. Muscle relaxants are beneficial for short-term use e.g., 1-2 weeks. Muscle relaxants can be considered as a first-line option for patients at risk for complications with use of acetaminophen or NSAIDs.
- Consider the use of topical analgesics such as Bengay, SalonPas, etc.
- Use of Integrative Therapies including but not limited to (section 3 Integrative Therapy Guidelines):
  - Mindfulness or yoga
  - Hot or cold compresses
  - Essential Oils

Patient treatment:
Treatment should be managed by the patient’s ability to achieve their functional goal, which is determined collaboratively with the patient and provider.
### 2c. TREATMENT OF LOW BACK PAIN, continued

#### Rationale for tests/treatment not recommended:

<table>
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<tr>
<th>Imaging tests:</th>
<th>According to the American College of Physicians and the American Pain Society(^\text{13}) there is no evidence that routine plain radiography in patients with nonspecific low back pain is associated with a greater improvement in patient outcomes than selective imaging. Routine advanced imaging (computed tomography [CT] or magnetic resonance imaging [MRI]) is also not associated with improved patient outcomes and identifies many radiographic abnormalities that are poorly correlated with symptoms but could lead to additional, possibly unnecessary interventions.</th>
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<tr>
<td>Opioids:</td>
<td>The JAMA article(^\text{20}) from October 20, 2015 states, “Among patients with acute, non-traumatic, non-radicular LBP presenting to the ED, adding cyclobenzaprine or oxycodone/acetaminophen to naproxen alone did not improve functional outcomes or pain at 1-week follow-up. These findings do not support use of these additional medications in this setting.”</td>
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<td>Physical Therapy:</td>
<td>The JAMA article(^\text{21}) from October 13, 2015 states “Among adults with recent-onset LBP, early physical therapy resulted in statistically significant improvement in disability, but the improvement was modest and did not achieve the minimum clinically important difference compared with usual care.”</td>
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2c. TREATMENT OF LOW BACK PAIN, continued

Patients with radicular pain, progressive pain, possible infection or tumor require additional assessment and treatment options:

- Expanded patient assessment: labs, imaging (Flexion and extension x-rays, CAT scan of impacted area, and/or MRI study) and possibly electromyogram. (Appendix B)

- Patient treatment: Treatment should be managed by the patient’s ability to achieve their functional goal, which is determined collaboratively with the patient and provider.
  - Utilize multimodal approach by:
    - Establishing a scheduled non-opioid foundation (may include NSAID’s or opioids). Discuss duration of scheduled pharmacotherapy with patient.
    - Consider the use of topical analgesics such as Bengay, SalonPas, etc.
    - If neuropathic pain only provide anti-convulsant treatment such as gabapentin
    - Consider antidepressants 5HT/NE reuptake inhibitors such as Tricyclic Antidepressants (TCA), venlafaxine, duloxetine
    - If opioids are needed for breakthrough pain follow section 2b. (Safe and Effective General Opioid Prescribing Guidelines for Acute Pain across the Care Continuum)
    - Do not use Soma Compound

- Consider physical therapy

- Consider referral to specialist if above treatment not effective to achieve established functional goal (interventional specialist, orthopedic/neurologist spine surgeon, oncologist, non-surgical back specialist, and/or rheumatologist). Other treatments include but are not limited to spinal injections and surgery.
2d. **OPIOID TAPERING GUIDELINES**

The treatment goals for chronic non-cancer pain emphasize improvement in function through the development of long-term self-management skills. This is best accomplished through an individualized, multimodal plan of care based on personalized treatment goals. Medications, including opioids, are only one component of the plan of care. Clinicians should consider opioid tapering and discontinuation when the patient fails to meet therapeutic goals or experiences intolerable side effects.

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<th>Consider if opioids should be discontinued if one or more of these conditions apply:</th>
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<td>• Failure to meet individualized functional and social goals</td>
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<td>• Medication fails to show significant analgesia despite incremental dose increases</td>
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<td>• Daily morphine equivalent dose is in excess of 90mg, or methadone daily dose is in excess of 40mg (adults), without clear sustained improvement in pain and function</td>
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<td>• Trials of different opioids at equivalent doses fail to provide adequate analgesia</td>
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<td>• Significant physical risk factors are present (sleep apnea, prolonged QT, pulmonary disease, etc.)</td>
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<td>• Side effects of medication are interfering with quality of life</td>
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<td>• The patient requests discontinuation</td>
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<td>• There is evidence of misuse, abuse, diversion, or other behavioral/psychological dysfunction</td>
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<th>Educate and involve patient and/or family on what to expect during the process:</th>
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<td>• Some short-term increase in pain may occur during the tapering process. The improved function and quality of life can offset the modest increase in pain.</td>
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<th>Ensure psychosocial support is available for patient:</th>
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<td>• Weaning is often associated with fear and anxiety about the recurrence or worsening of pain and/or the development of other withdrawal symptoms. Reassure the patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include replacement medications such as other opioids or benzodiazepines. Certain medications that treat autonomic responses, medications such as clonidine, loperamide, or hydroxyzine may be useful short-term adjuncts.</td>
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## 2d. OPIOID TAPERING GUIDELINES, continued

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<th><strong>Opioid tapering protocol:</strong></th>
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<tr>
<td>• Involve patient and/or family in the opioid tapering process</td>
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<td>○ The slower the taper, the less the short-term discomfort. Educating the patient about the risks of their current regimen and what to expect as they taper off the medications can be helpful.</td>
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<td>○ Some highly motivated patients prefer a rapid taper (weeks versus months). Patient preference needs to be considered in designing a tapering schedule.</td>
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<tr>
<td>• Taper the removal of opioids to avoid symptoms of withdrawal (nausea and vomiting, abdominal cramps and diarrhea, agitation, muscle aches, insomnia, increased salivation, sweating, and goose bumps).</td>
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<tr>
<td>○ Teach patients about symptoms of opioid withdrawal</td>
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<td>• Convert the total daily opioid dose taken by the patient into a daily morphine equivalent. (Use an equianalgesic scale. The calculated equianalgesic dose should be reduced by approximately 25% due to incomplete cross-tolerance.).</td>
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<td>• Decrease daily dose by 10% each week</td>
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<td>• If signs of withdrawals occur, or once the daily intake has reached 25-50% of the starting dose, slow the taper to decrease dose by 10% every 2-4 weeks, or 5% each week.</td>
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<td>• Methadone has a long half-life, and as a result, withdrawal symptoms may be delayed. It is recommended that the same tapering schedule be initiated</td>
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<td>○ If a urine drug screen is indicative of substance abuse, or patient’s behavior indicates possible misuse or diversion of controlled substances (i.e., selling drugs, unauthorized dose escalation), rapid discontinuation is advised (reduce by 15-30% daily over 7 days). Referral to a detoxification center or medication-assisted treatment program is advisable. As the patient in this case may experience withdrawal symptoms, using adjunct medications to mitigate these symptoms may be needed.</td>
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## 2d. OPIOID TAPERING GUIDELINES, continued

### Management of Withdrawal Symptoms:
- Assess patient for withdrawal symptoms using a reliable and valid withdrawal assessment tool.
- The following medications may be helpful in reducing the intensity of withdrawal symptoms (The symptoms addressed are in parenthesis):
  - Clonidine (hypertension)
  - Loperamide (diarrhea)
  - Ondansetron (nausea and vomiting)
  - Hydroxyzine or diphenhydramine (anxiety)
  - Acetaminophen or ibuprofen (pain)
  - Methocarbamol (muscle spasm) – avoid carisoprodol

### Maintenance:
- Once the patient has decreased their dose during the tapering process, support the patient rather than increasing the dose when a short-term increase in pain or side effects occurs.
- Provide patient with plan for short-term pain management escalation.

## 2e. MANAGEMENT OF ACUTE PAIN FOR THE OPIOID TOLERANT PATIENT

### Populations impacted
- Acute pain related to a new injury or procedure independent of the chronic pain problem (cancer or noncancerrelated chronic pain)
- Acute pain in the patient on opioid maintenance therapy for addiction
- Acute pain in the opioid dependent patient from illicit drug use. Pain related to opioid withdrawal is out of scope of this guideline.
- Exacerbation or flare of the chronic pain problem should not be treated as acute pain.
2e. MANAGEMENT OF ACUTE PAIN FOR THE OPIOID TOLERANT PATIENT, continued

<table>
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<th>Treatment goals:</th>
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<tr>
<td>• Provide adequate analgesia</td>
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<tr>
<td>• Proactive management to minimize potential for developing side effects or reduce the intensity of treatment related side effects</td>
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<tr>
<td>• Prevent withdrawal from opioids as well as adjuvant medications e.g., benzodiazepines, antidepressants, etc.</td>
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<tr>
<td>• Proactive management to minimize impact or exacerbation of chronic pain as a result of the acute pain problem or its treatment</td>
</tr>
<tr>
<td>o Ongoing management of chronic pain will be referred back to the outpatient provider and is out of scope of this guideline</td>
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<tr>
<td>• Avoid relapse for patient with history of substance use disorder</td>
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<th>Treatment challenges:</th>
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<tr>
<td>• Early identification of opioid habituated patients</td>
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<tr>
<td>o For elective procedures, advance notification to appropriate stakeholders of the procedure / admission to facilitate development of pain management plan</td>
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<tr>
<td>• Opioid tolerance</td>
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<tr>
<td>o According to the American Society of Addiction Medicine opioid tolerance is a predictable physiological decrease in the effect of a drug over time so that a progressive increase in the amount of that drug is required over time</td>
</tr>
<tr>
<td>o Patients will likely require higher doses of opioid to manage acute pain due to tolerance</td>
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<tr>
<td>• Physical dependence</td>
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<tr>
<td>o A physiological adaptation to a drug whereby abrupt discontinuation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist produces a withdrawal syndrome</td>
</tr>
<tr>
<td>• Potential for opioid-induced hyperalgesia</td>
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<tr>
<td>o Administration of opioids can produce a paradoxical increase in pain sensitivity</td>
</tr>
<tr>
<td>• Central sensitization</td>
</tr>
<tr>
<td>o In patients receiving chronic opioid therapy, chronic stimulation of opioid receptors produces increased sensitivity to pain through multiple mechanisms</td>
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### Evaluation:

- Differentiate between exacerbation of chronic pain or new pain problem<sup>25</sup>
- Accurate medication reconciliation – quantify opioid consumption
  - Identify and obtain opioid agreement
  - Contact opioid prescriber(s) directly to obtain validate dosage
  - Check state drug monitoring database
- Utilize a urine drug screen if red flags identified e.g., opioid prescriptions from multiple providers/multiple clinics, early refills, multiple Emergency Department visits for general pain complaints, cutaneous signs such as skin tracts or scars<sup>28</sup>
  - Opioid screening tests, usually performed on urine samples, have certain limitations. Specifically, the method of collection can include diversionary tactics where the patient substitutes a sample obtained from another individual. The screening tests do not always include all possible medications that the patient is taking, prescribed or not. For example, many screening tests performed in hospitals do not include methadone and oxycodone, two drugs commonly prescribed and abused.
  - To ensure that all substances of interest are included, the provider should consult with the Clinical Laboratory, and, if needed, ask for additional assays to be performed.
- Determine patient’s baseline chronic pain intensity and function; this helps determine realistic goals for acute pain treatment
- Discuss treatment goals related to chronic pain and identify how the acute pain problem impact these goals
- Screen for presence or exacerbation of psychiatric disorders as needed
- Complete risk assessment for use/increased doses of opioids; identify strategies to mitigate risk
- Process check:
  - Identify if patient is at risk for poorly controlled pain or withdrawal
  - Collaborate with outpatient provider(s) to clarify medication treatment plan and goals of care
  - Communicate findings to members of the healthcare team
  - Communicate to outpatient provider(s) at time of transition back to outpatient care
### 2e. MANAGEMENT OF ACUTE PAIN FOR THE OPIOID TOLERANT PATIENT, continued

<table>
<thead>
<tr>
<th>Treatment planning:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintain baseline opioids when possible, especially sustained release medications; replace with different drug and route if needed to cover baseline pain and analgesic needs³⁷</td>
</tr>
<tr>
<td>• Utilize short-acting opioids for acute pain: oral immediate release opioid or intravenous (IV) patient controlled analgesia (PCA)</td>
</tr>
</tbody>
</table>
| • Multimodal therapy is a must¹³  
  ○ Interventional analgesia where services are available |
| • Address side effect prevention and management to reduce intensity of treatment related side effects |
| • Methadone maintenance  
  ○ Verify dosing and treatment plan with prescriber/program  
  ○ Continue baseline methadone regimen  
  ○ Immediate release opioids titrated to patient need  
  ○ Concurrent use of methadone with supplemental opioid may increase risk of developing adverse effects and requires careful monitoring and titration of the immediate release opioid¹, ³⁴ |
| • Buprenorphine (Buprenex; Butrans; Subutex); buprenorphine and naloxone (Suboxone)  
  ○ Verify dosing and treatment plan with prescriber  
  ○ Consult anesthesia, pain management, or addiction specialists to determine whether or not to continue buprenorphine based on individualized patient assessment and resource support.¹, ³⁴, ³⁷ |
| • For all patients under active treatment for opioid addiction, it is essential to communicate with the patient’s Addictionologists to individualize the acute pain treatment plan. |
| • N-methyl D-aspartate (NMDA) antagonists as part of a multimodal, perioperative approach  
  ○ These modalities are usually managed by the anesthesiologist in the perioperative period.  
  ○ NMDA receptors can be bound by sub anesthetic ketamine bolus and/or infusion as an adjunct for chronic pain patients within the perioperative period.²³, ⁴³  
  ○ Dextromethorphan given preoperatively to decrease pain and opioid requirements³³ |
2e. MANAGEMENT OF ACUTE PAIN FOR THE OPIOID TOLERANT PATIENT, continued

Discharge planning begins at time of admission:

- Communicate (verbal and/or written) with outpatient treatment provider
  - Analgesic/opioid adjustments and expected treatment duration
  - Identify who will manage acute pain and analgesics and for what duration of time
  - Follow-up established with outpatient prescriber

- Refer to Safe and Effective General Opioid Prescribing Guidelines on transition from facility

2f. HOSPITAL–BASED PAIN MANAGEMENT ORDERS

According to the National Institutes of Health pain affects more people than diabetes, heart disease, cancer and stroke combined. Ascension’s focus on improved pain management is a top priority to address this national issue. Per The Joint Commission, opioid analgesics rank among the drugs most frequently associated with adverse drug events.

The purpose of these recommendations is to provide guidance on developing and implementing safe, evidence-based management orders that are regulatory compliant. The goal is to provide pain management that allows the patient to participate in their healthcare recovery/treatment. Important points include:

- Do not link pain intensity (mild/moderate/severe or numeric values) to pain medication dose
- Utilize multimodal approach by:
  - Establishing a scheduled non-opioid foundation
  - Increasing the use of integrative therapies
- Integrate safety components such as assessment of a patient’s risk, establishing safe monitoring processes and hold/do not administer opioid guidelines

Implement a valid and reliable opioid sedation assessment tool as appropriate for all patient populations

- Pasero Opioid-Induced Sedation Scale (POSS) for all adults and non-critically ill children
- Neonatal Pain Agitation Sedation Scale (NPASS) for Neonates in the NICU (premature to 100 days of life)
- Comfort B for critically ill pediatric patients in the ICU (age 100 days of life to 18 years old)
### 2f. HOSPITAL–BASED PAIN MANAGEMENT ORDERS, *continued*

<table>
<thead>
<tr>
<th>Structure of pain medication orders in order sets and as an individual order</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>• Ensure order sets address pain management</strong></td>
</tr>
<tr>
<td>○ Consider one pain management order set in which all other order sets link to for consistency in delivering evidence-based pain management</td>
</tr>
<tr>
<td><strong>• Pain intensity descriptors: Do not link pain intensity (mild/moderate/severe or numeric values) to pain medication dose</strong></td>
</tr>
<tr>
<td><strong>• Structure pain medication order to promote use of scheduled non-opioid foundation</strong></td>
</tr>
<tr>
<td><strong>• Safety components for opioid orders</strong></td>
</tr>
<tr>
<td>○ General criteria:</td>
</tr>
<tr>
<td>□ Directions can be in either order statement/comments section, link to criteria or in policy</td>
</tr>
<tr>
<td>□ Ensure directions are available/visible to both prescribing provider and administering clinician</td>
</tr>
<tr>
<td>□ Ensure provider has ability to individualize to patient needs as indicated</td>
</tr>
<tr>
<td>○ Add directions when to hold or not administer an opioid dose</td>
</tr>
<tr>
<td>□ Criteria</td>
</tr>
<tr>
<td>▪ Sedation level of “x”</td>
</tr>
<tr>
<td>▪ Respiratory assessment [including depth, regularity and respiratory rate (RR) of “x/min”]</td>
</tr>
<tr>
<td>▪ Snoring</td>
</tr>
<tr>
<td>▪ Systolic Blood Pressure (SBP) less than “x”</td>
</tr>
<tr>
<td>○ Recommended standard</td>
</tr>
<tr>
<td>□ Adult: Sedation level greater than 2 (using POSS), shallow respirations, RR less than 10/min, presence of snoring, SBP less than 90</td>
</tr>
<tr>
<td>□ Pediatric:</td>
</tr>
<tr>
<td>▪ Newborn 0-1 month: RR less than 30, presence of snoring, pausing or grunting, SBP less than 73</td>
</tr>
<tr>
<td>▪ Infant 1-12 months: RR less than 30, presence of snoring, pausing or grunting, SBP less than 90</td>
</tr>
<tr>
<td>▪ Toddler 1-3 years: RR less than 25, presence of snoring, pausing or grunting, SBP less than 95</td>
</tr>
<tr>
<td>▪ Preschool 3-5 years: RR less than 22, presence of snoring, pausing or grunting, SBP less than 99</td>
</tr>
<tr>
<td>▪ School age 6-11 years: RR less than 20, presence of snoring, pausing or grunting, SBP less than 97</td>
</tr>
<tr>
<td>▪ Pre-adolescent 11-13 years: RR less than 18, presence of snoring, pausing or grunting, SBP less than 105</td>
</tr>
<tr>
<td>▪ Adolescent 13-18 years: RR less than 16, presence of snoring, pausing or grunting, SBP less than 110</td>
</tr>
</tbody>
</table>
### Structure of pain medication orders in order sets and as an individual order

- Add directions when IV and PO opioid order exists simultaneously
  - Consider if the patient can eat, oral can treat
  - Consider link to document for peak opioid medications times
  - Consider IV route for severe pain that is unresponsive to oral medication or if patient unable to tolerate PO
  - Consider adding order for Naloxone for emergent treatment

- If utilizing range orders:
  - Consider how application manages charges (1 tab versus 2)
  - Ensure policy and procedure outlines requirements of range orders
    - Range order for dose only.
    - Never have range orders for frequency and/or both dose and frequency options.
  - Educate and monitor nursing and provider compliance to ensure consistent application and interpretation of range orders.

### Assess patient risk prior to prescribing

- Follow local policy
- Characteristics of patients who are at higher risk for over-sedation and respiratory depression
  - Sleep apnea or sleep disorder, snoring
  - Morbid obesity with high risk of sleep apnea
  - Age (61 and higher)
  - No recent opioid use
  - Abdominal or thoracic post-surgical patient
  - Increased opioid dose requirement or opioid habituation
  - Longer length of time receiving general anesthesia during surgery
    - Receiving other sedative medications such as anti-nausea medication, sedating muscle relaxers, sleeping medication, diphenhydramine, hydroxyzine or benzodiazepines
    - Pre-existing pulmonary or cardiac disease or dysfunction or major organ failure
    - Thoracic or other surgical incisions that may impair breathing
    - Smoker

- Factors in addition to pain intensity that can influence opioid dose requirement *(Appendix A)*

- Assess or obtain sedation level using identified valid and reliable sedation assessment tool, prior to prescribing opioids
  - If nurse is calling provider for an opioid order, provide sedation level
  - If nurse does not provide, provider is to ask for sedation level
Prescribing of pain management orders in a manner that is safe and effective so that the patient can participate in their healthcare recovery/treatment

- Use multimodal approach:
  - Unless contraindicated, prescribe scheduled non-opioid foundation
  - Increase use of integrative therapies as available in ministry and appropriate for patient age, examples includes but is not limited to the following list. (Section 3 - Integrative Therapy).
    - Aromatherapy
    - Nutritive sucking
    - Distraction methods
    - Decreased stimulation
    - Therapeutic touch
    - Deep breathing
    - Guided imagery
    - Music Medicine
    - Massage
  - Follow evidence based use and storage of oral sucrose for pediatric patients
  - If prescribing an opioid
    - Avoid therapeutic duplication for the same route and indication
    - Review and adjust hold or do not administer parameters
  - For surgical patients consider scheduling dose for the first 24 hours
  - Unless non-opioid contraindication, an opioid medication should not be the only pain medication available
  - Develop treatment guidelines to address opioid-related side effects

Decision making process to determine which prn medication and dose to administer to patient

- Patient requests pain medications
  - Assess patient
    - Consistently use pain assessment tool that is appropriate for patient condition
    - Pain assessment score compared to acceptable level
    - Minimum pain assessment parameters include intensity, description or location
    - If patient is receiving opioids also include sedation level of patient. This will inform the clinician if opioid can be given to patient safely or not.
      - This should include a true count of respiratory rate, and observation of depth and quality
      - When the patient is sleeping, his/her respiratory rate should be assessed prior to other vital signs so as not to obtain a rate after waking someone
  - Decision
    - Can I safely administer prn medication based on patient assessment and prescribed dose/frequency? Is the patient able to participate in his/her healthcare recovery/treatment?
      - If yes, administer per order
      - If no, document why, and continue monitoring patient and notify provider
### Monitoring

- More vigilant monitoring of sedation and respiratory status should be performed when patients may be at greatest risk for adverse events:
  - Peak of medication effect
    - IV 30 minutes
    - PO 60 minutes
  - During the first 24 hours after surgery
    - Abdominal or thoracic surgery
  - After an increase in the dose of an opioid
  - Coinciding with aggressive titration of opioids
  - Recent or rapid change in end-organ function (specifically hepatic, renal, and/or pulmonary)
  - When switching from one opioid to another or one route of administration to another
  - Anesthesia
    - Within the first 6 hours after anesthesia
    - Patient had greater than 3 hours of anesthesia within 24 hours
  - During the hours of 11 p.m. and 7 a.m.
  - Smoker
  - Obstructive sleep apnea or snoring
  - BMI greater than 40
  - Greater than 75 years old

- Monitoring recommendations
  - SaO2
  - ETCO2 if available per local policy

### Recommendations for transferring to another level of care

- Do not transfer patients between levels of care near the peak effect of the administered opioid.
  - IV 30 minutes
  - PO 60 minutes

- Handoff communication (verbal or written)
  - Share sedation scores
  - Share respiratory rate, depth and quality
  - Provide detailed information about medications given to patient, especially any sedating medication
  - Share what non-pharmacologic agents work for the patient
  - Share how the pain medication has been working for the patient
  - Share patient’s acceptable level of pain (pain goal) and functional activity goals
2g. INCORPORATING ACUTE PAIN MANAGEMENT INTO EVERYDAY PRACTICE

Provide pain management education for all associates. Pain management is everyone's responsibility and is in connection with our System’s Mission, Vision and Values as we strive to be a Highly Reliable Organization.

- **Huddles**
- **Rounding**
  - Hourly Rounding: Part of hourly rounding is assessing patients pain/comfort
  - Leadership/Physician Rounding
    - Assess completion of communication boards
    - Educate patient:
      - “I am ___ and I am a representative from ____. We strive to provide the best communication with our patients, and we are encouraging everyone to use the communication board to share information with you. Hopefully this is working for you, and I would like to also see how your pain plan is being managed as we want to ensure that we do everything that we can to help control your pain.”
  - Transition Rounding: Address pain management issues

- **Communication Boards**
  - Educate patient and family on use of communication board
  - Document throughout day
    - Acceptable level of pain
    - What works for me
    - Pain level ___/___
    - Last pain medication given
    - Transition plan from IV to oral medication
  - Consider implementing an audit process to evaluate communication board completion and quality of content.
2g. INCORPORATING ACUTE PAIN MANAGEMENT INTO EVERYDAY PRACTICE

Scripting for all levels: nurses, physical therapy, transition planners, physicians, dyad leaders, leadership

Provider:
- “I see your acceptable level of pain is “x”. How is your pain now?”
- If patient’s pain is uncontrolled, “I am going to change your pain medication. Some pain is expected. We are trying to keep you comfortable with the pain control, but also have you being able to walk which promote healing.”
- If no pain reported, reinforce that pain/comfort goals have been achieved

- “Did your doctor talk to you about your acceptable level of pain?”
- “Did your doctor discuss your pain management plan with you?”

2h. DISPOSAL OF UNUSED CONTROLLED SUBSTANCES

Unused portions of medicines must be disposed of properly to avoid harm to others and the environment. Certain medicines, such as opioids, may be especially harmful and, in some cases, fatal in a single dose if they are used by someone other than the person the medicine was prescribed for.

Patient Education
- Educate patient/family when prescribing or stopping medication to remove expired, unwanted, or unused medicines from their home as quickly as possible to help reduce the chance that others may accidentally take or intentionally misuse the unneeded medicine.
- Provide patient with list of take back programs in the area (this is preferred method)
### 2h. DISPOSAL OF UNUSED CONTROLLED SUBSTANCES, continued

<table>
<thead>
<tr>
<th>Patient Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Identify “take-back programs” available in your area(^5),(^6)</td>
</tr>
<tr>
<td>- If there are not medicine “take-back programs” or DEA-authorized collectors available in your area, you can also follow these simple steps to dispose of most medicines in the household trash:</td>
</tr>
<tr>
<td>○ Mix medicines (do not crush tablets or capsules) with an unpalatable substance such as dirt, kitty litter, or used coffee grounds</td>
</tr>
<tr>
<td>○ Place the mixture in a container such as a sealed plastic bag</td>
</tr>
<tr>
<td>○ Throw the container in your household trash</td>
</tr>
<tr>
<td>○ Remove all personal information on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable, then dispose of the container</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ministries and Healthcare Locations Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Do not flush most medication as it damages water supply. This list from the FDA provides what expired, unwanted, or unused medicines you should flush down the sink or toilet to help prevent danger to people and pets in the home. <a href="#">Click here</a> for list</td>
</tr>
<tr>
<td>- Facilities to define process to dispose of controlled substances that follow state and national regulatory bodies. Must ensure that the chemical composition of the substance has changed.</td>
</tr>
<tr>
<td>○ Follow facilities’ policy for disposal</td>
</tr>
</tbody>
</table>
### 2i. Referral to Addiction Specialist

This provides guidance on when to refer a patient to an addiction specialist and what qualifications to look for in an addiction specialist.

<table>
<thead>
<tr>
<th>When it is appropriate to refer to Addictionologists?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• History of prior or current addiction or who are abusing prescribed medications. Validate patient dose with current treatment center.</td>
</tr>
<tr>
<td>• Patient is resistant to tapering process [section 2d. Opioid Tapering Guidelines]</td>
</tr>
<tr>
<td>• May or may not be motivated to address issues in treatment</td>
</tr>
<tr>
<td>• Positive urine drug screen for illicit drugs as defined by individual program level of care guidelines</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Partner with qualified Addictionologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider qualifications</td>
</tr>
<tr>
<td>○ Board certified or eligible [American Board of Addiction Medicine (ABAM) or American Board of Psychiatry and Neurology (ABPN) preferred], Fellowship trained or spends greater than 20% of professional time</td>
</tr>
<tr>
<td>○ Works with substance use disorder (SUD) patients</td>
</tr>
<tr>
<td>○ Has DEA licensure to prescribe buprenorphine products OR works within an Outpatient Treatment Center (methadone)</td>
</tr>
<tr>
<td>○ Have sufficient knowledge of pain management to effectively communicate with patients and other providers</td>
</tr>
<tr>
<td>○ Physician willing to help with tapering of opioids</td>
</tr>
<tr>
<td>• Quality expectations</td>
</tr>
<tr>
<td>○ Provides a written consultation report to referral source within reasonable time</td>
</tr>
<tr>
<td>○ Able to see patients in timely manner; usually less than one month with some room for urgent patients</td>
</tr>
<tr>
<td>○ Provides counseling services internally or has certified therapists for referral</td>
</tr>
<tr>
<td>• Office expectations</td>
</tr>
<tr>
<td>○ Accepts most insurance products</td>
</tr>
<tr>
<td>○ Access to detoxification program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral process:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Make referral with the patient present or via three-way phone call between referral provider, Addictionologists and patient/family</td>
</tr>
<tr>
<td>• Have the patient sign release for appropriate communication from referral provider to Addictionologists</td>
</tr>
<tr>
<td>• Obtain urine drug screen prior to referral (24 hour notice)</td>
</tr>
<tr>
<td>• Have process to confirm that appointment has been made</td>
</tr>
</tbody>
</table>
2i. REFERRAL TO ADDICTION SPECIALIST, continued

**Opioid Tolerant:** Patients who are taking at least 60 mg of oral morphine/day, 25mcg transdermal fentanyl/hour, 30 mg oral ocyCODONE/day, 8 mg oral HYDRO morphine/day, 25 mg oral oxymorphone/day or an equianalgesic dose of another opioid for one week or longer.³

**Opioid Naïve:** Patients who do not meet the definition of opioid tolerant.³

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2j. COGNITIVE BEHAVIORAL THERAPY (CBT)

Chronic pain is a complicated health issue. Cognitive and behavioral aspects play a part in the symptoms and treatment plan. According to the National Association of Cognitive-Behavioral Therapists (CBT), CBT is a form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do. The behavioral components include relaxation and biofeedback while the cognitive components include cognitive restructuring and cognitive coping skills training.

There is evidence that states CBT reduces pain immediately following a treatment, reduces disability immediately following treatment, and improves mood and reduces psychological distress for up to six months. The goal is not to eliminate pain, but to teach patients how to have productive lives despite their pain. This is accomplished by encouraging patients to engage in problem solving and self-management.

For more information review [May 2016 presentation and materials](https://example.com/cbt-materials).
3a. INTEGRATIVE THERAPIES BACKGROUND

Our philosophy of care underscores our heritage as a faith-based health system offering our patients so much more than medicine. Health and healing involves all aspects of the whole person (mind-body-spirit dimensions). Integrative health and medicine emphasizes the integration of complementary and alternative medicine (CAM) approaches with traditional medicine to support the body’s innate healing response and offers best practices for optimal health and healing.

Research shows that the safest and the best way to minimize pain include using a variety of treatments (multimodal therapy). Treatments include medications such as ibuprofen (i.e. Advil), acetaminophen (i.e. Tylenol), and the more powerful opioid medications. Due to the safety, side effects and potential for addiction, opioids should only be taken under the guidance of a licensed professional. The use of integrative therapies, also known CAM, can be effective treatments. Integrative therapies focus on treatment for the whole person through a variety of techniques or treatments. Many people believe integrative therapies are effective and generally safe as they have little to no side effects compared to medications.

The goal is to create awareness and provide options for integrative therapy solutions to use in conjunction with evidence-based pain management treatments. Since ministries have different offerings, it is recommended to create a listing of integrative therapies that are available and can be offered to the patient. This will help clinicians have the dialogue with the patient on what might be useful, while educating the patient on possible therapies to try. Many of these therapies can be used for patients across the care continuum. Brief information on each integrative therapy is included in the guidelines. Follow this link to obtain more detailed information about each integrative therapy: Click here
3b. CLINICAL AROMATHERAPY

Indication Guidelines for Clinical Aromatherapy

According to the National Association for Holistic Aromatherapy, aromatherapy is the art and science of utilizing naturally extracted aromatic essences from plants to balance, harmonize and promote the health of body, mind and spirit. It seeks to unify physiological, psychological and spiritual processes to enhance an individual’s innate healing process. Clinicians must be trained to administer aromatherapy. Aromatherapy can be inhaled, applied topically or by diffusion.

AROMATHERAPY SCENTS HAVE SPECIFIC USES:

Lavender (Lavandula angustifolia)

**Indications:** Used for calming, relaxing and balancing effects, both physically and emotionally. May be helpful for patients experiencing insomnia, stress, muscle spasms, headaches, anxiety, irritability, and/or nausea. Lavender’s floral and slightly herbal aroma is used for its antiseptic, analgesic, anti-inflammatory and wound healing properties.

Ginger (Zingiber officinale)

**Indications:** Digestive disorders (nausea, motion sickness, indigestion), may reduce pain, and help with loss of appetite, congestion, and sinusitis. Ginger’s warm, balsamic and woody scent has anti-inflammatory, analgesic, expectorant, antiseptic and antispasmodic properties.

Peppermint (Mentha piperita)

**Indications:** Used for indigestion, nausea, and headaches. Peppermint’s strong, minty aroma is used for pain relief, with antispasmodic, analgesic, anti-inflammatory properties. It is also effective for depression and mental fatigue.

*Use with caution if patient is experiencing an acute episode of a-fib or tachycardia*

Sweet Orange (Citrus sinensis)

**Indications:** Used for anxiety, nervousness, and insomnia. Sweet orange properties are: antidepressant, antispasmodic, digestive, sedative and antiseptic.

For more information review [February 2016 presentation and materials](#).
3c. GUIDED IMAGERY

A form of focused relaxation that directs the imagination to create calm, peaceful images in the mind to bring about a desired physical response.

- Involves all 5 senses, the whole body, and emotions.

- Shown to reduce stress, balance immune response, manage acute and chronic pain, reduce chemotherapy side effects, promote sleep, and reduce fear & anxiety.

- An important adjunctive therapy to conventional treatment.

- Most effective in group settings, with the use of music, and when it matches a person’s values and comfort level.

- Can be delivered by a practitioner, video, audio recording, or conducted by the individual.

- Low cost, portable, can be self-administered with minimal guidance, and no known side effects for most people.
3d. HEALING TOUCH

Healing touch is a holistic, relaxing and nurturing energy therapy. Healing touch works with your energy field to support your natural ability to heal. Practitioners consciously use their hands in a heart-centered and intentional way to enhance, support and facilitate physical, emotional, mental, spiritual health and self-healing. Utilizing light or near-body touch to clear, balance and energize the human body energy field to promote health and healing to mind, body and spirit. The Healing Touch Program is nationally accredited by the American Nurses Credentialing Center (ANCC) and is endorsed by the American Holistic Nurses’ Association.

Healing touch is safe for all ages and works in harmony with standard medical care. The goal is to restore balance and harmony to the body’s energy system so the patient can heal. Healing touch can be used in all care settings.

The benefits include:

- Reducing stress, anxiety, fatigue, tension, pain; calming anxiety, depression
- Reducing hospital length of stay, enhancing recovery from surgery, facilitating wound healing
- Strengthening the immune system; disease appears in the energy field before it appears in body
- Complementing care for neck and back problems
- Deepening spiritual connection; creating a sense of well-being
- Supporting cancer care; easing acute & chronic conditions, supporting patients and families

The healing touch process includes 10 steps:

1. Intake  
2. Assessment/Intuitive response  
3. Goal setting  
4. Pre-treatment client energy assessment  
5. Practitioner preparation  
6. Treatment/Interventions  
7. Post-energy assessment  
8. Ground and release the client  
9. Client feedback, practitioner observation and evaluation  
10. Plan and growth

For more information review January 2016 presentation and materials.
3e. HOT AND COLD THERAPY | click here for complete document

Box 9.2 Patient Information: Use of Cold

Cold may relieve the following types of pain, and it often works better than heat:
- Muscle aches or spasms, such as neck or low back pain
- Joint pain
- Headache
- Surgical incision
- Itching

Precautions:
- Do not use cold over areas of poor circulation or skin being treated with radiation therapy.
- Do not use cold if pain increases.
- Think cool, not cold. Keep the sensation of cold at a cool, comfortable level.
- Cover the cold pack with a towel.
- Remember that moisture increases the intensity of cold.
- Remove cold pack if skin becomes numb.
- Do not freeze your skin.

Equipment for cold can be any of the following:
- Ice bag
- Gel pack
- Ice and water in a plastic bag
- A bag of frozen peas or corn kernels (hit the bag on the countertop to break up the frozen vegetables so it will mold to your skin).
- Slush pack made by freezing in a sealed plastic container (e.g., plastic bag) 1/3 alcohol and 2/3 water
- Towel soaked in water and ice chips and wrung out.
- Flexible cold pack made with a damp cloth or towel, folded in the desired shape, sealed in a plastic bag, and placed in the freezer.

Application of cold:
- Cover ice pack with a pillowcase or one or more towels.
- Keep it at a comfortably cool intensity.
- Apply to painful area for 10 to 20 min. You may use cold for any length of time if it remains at a comfortable level of coolness that does not irritate your skin.
- If you cannot get to the area that hurts, apply the cold pack to any or all of the following sites:
  - Opposite side of body corresponding to the pain (e.g., left leg if right leg hurts)
  - Above the pain (e.g., over upper arm if lower arm hurts)
  - Below the pain (e.g., over lower arm if upper arm hurts)

Box 9.3 Patient Information: Use of Heat

Heat may relieve the following types of pain:
- Muscle aches or spasms, such as neck or low back pain
- Joint pain
- Itching
- Rectal pain

Precautions:
- Do not use heat if pain increases.
- Think warm, not hot. Keep the sensation at a warm, comfortable level.
- Cover heat source with a towel.
- Remember that moisture increases the intensity of heat.
- Do not use heat over skin where menthol ointment or an oily substance has been applied.
- Do not use over an area that is bleeding or recently injured.

Equipment for heat application can be any of the following:
- Hot water bottle
- Electric heating pad
- Hot moist compresses (e.g., towel)
- Immersion in water (e.g., tub, basin, whirlpool)
- Retention of body heat with plastic wrap (e.g., Saran Wrap, plastic dry cleaner bag taped to itself). Be careful to wash and dry your skin well at least once a day if you are using this method.

Application of heat:
- Cover heat source with a pillowcase or one or more towels.
- Keep it at a comfortably warm intensity.
- Do not fall asleep on top of an electric heating pad.
- Apply to painful area for 10-20 min. You may use warmth for any length of time if it remains at a comfortable level that does not irritate your skin.
- If you cannot get to the area that hurts, apply the heat pack to any or all of the following sites:
  - Opposite side of body corresponding to the pain (e.g., left leg if right leg hurts)
  - Above the pain (e.g., over upper arm if lower arm hurts)
  - Below the pain (e.g., over lower arm if upper arm hurts)

3f. TECHNIQUES WITH NEEDLESTICKS

Immunizations, blood draw or starting an IV is often dismissed as just “one little stick”. However, it’s the culmination of these “little sticks” over time from infant to adult that can lead to needle phobia. A study identified that needle phobia has increased 150% in less than two decades. This can lead to immediate and long-term consequences such as fear of needle sticks and fainting to avoidance of healthcare such as immunizations, blood tests, dental care and life saving procedures. This presentation offers solutions to managing needle sticks.

For more information review October 2015 presentation and materials.

3g. LAUGHTER

According to verywell.com research has shown that the health benefits of laughter are far-ranging. Laughter can help relieve pain, bring greater happiness, and even increase immunity.

FUNCTIONS OF HUMOR

| Psychological: | Acts as a major coping mechanism; relieves anxiety and tension, serves as outlet for hostility and anger, provides healthy escape from reality, and lightens heaviness related to critical illness, trauma, disfigurement, and death. |
| Social: | Lessens the hierarchy between individuals, establishes rapport, and decreases social distance. |
| Communication: | Helps convey information; opens the door for communication by allowing one to bring up a secretly serious subject to see how it will be received while providing an ‘out’ such as “I was only joking’’ aids in negotiation; defuses hostile conversations. |

PHYSIOLOGY OF LAUGHTER

| Respiratory system: | Increases respiratory activity and oxygen exchange. |
| Cardiovascular system: | Stimulates heart rate and blood pressure followed by a relaxation phase; vasodilatation; elasticity of endothelial lining of blood vessels. |
| Sympathetic Nervous system: | Increases production of catecholamines resulting in increased levels of alertness and memory; enhances learning and creativity. |
| Immune system: | Immunoglobulin A found in significantly increased levels of saliva with stimulation of humor and laughter; increased spontaneous lymphocyte blastogenesis, a natural killer cell activity. |
| Muscle system: | Stimulates skeletal muscles and relaxes muscle tension, often resulting in diminished pain. |
3g. LAUGHTER, continued

PHYSIOLOGY OF LAUGHTER, continued

Brain: Laughter stimulates both hemispheres at the same time, coordinating all the senses and producing a unique level of consciousness and a high level of brain processing. Humor produces increase in gamma waves across entire brain. Improvement seen in short-term memory in subjects over 50 years of age.

Digestive Tract: Internal organs massaged resulting in increased peristalsis, improved digestion.

Tears (of laughter and grief): Excrete toxins (exocrines) found in cells under stress.

For more information review 2015 Pain Management Summit.

3h. MASSAGE

Massage has been used as a treatment modality off and on for centuries. Massage therapy is formally defined as the manual manipulation of soft body tissues (muscle, connective tissue, tendons and ligaments) to enhance a person’s health and wellbeing.

MASSAGE:

| • Improves relaxation | • Improves physical performance |
| • Promotes better health and sleep | • Helps in trauma therapy |
| • Reduces pain |

Massage has both mechanical and physiological effects. The mechanical effects include breaking up knots or adhesions and restoring muscles to proper length through kneading and stretching. The physiological effects are that it is both relaxing and stimulating. It increases circulation which facilitates oxygen and nutrient delivery, endorphins, serotonin and others.

For more information review March 2016 presentation and materials.
PRINCIPLES OF HIGHLY RELIABLE CARE: ASCENSION PAIN MANAGEMENT GUIDELINES: INTEGRATIVE THERAPIES

3i. MUSICAL MEDICINE

Music medicine is the intentional use of specific music and/or sound to effect a change in physiology and/or emotions, and the transpersonal. The biomedical goals of Music Medicine are that it:

<table>
<thead>
<tr>
<th>Increases</th>
<th>Decreases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination</td>
<td>Pain</td>
</tr>
<tr>
<td>Muscle Recruitment</td>
<td>Nausea</td>
</tr>
<tr>
<td>Mood</td>
<td>Depression and Anxiety</td>
</tr>
<tr>
<td>Immune System</td>
<td>Hospital Stay</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Pulse Rate</td>
<td>Pulse Rate</td>
</tr>
<tr>
<td>Exhalation Ability</td>
<td>Intracranial Pressure</td>
</tr>
<tr>
<td>Muscle Tension</td>
<td>Muscle Tension</td>
</tr>
<tr>
<td>Respiration Rate</td>
<td>Respiration Rate</td>
</tr>
<tr>
<td>Walking Speed</td>
<td>Crying</td>
</tr>
<tr>
<td>EMG Levels</td>
<td>Analgesics</td>
</tr>
<tr>
<td>Effects of Anesthesia</td>
<td>Effects of Anesthesia</td>
</tr>
<tr>
<td>Grasp Strength</td>
<td>Use of Sedatives</td>
</tr>
<tr>
<td>Healing</td>
<td></td>
</tr>
</tbody>
</table>

The protocol for pain relief is to:
- Direct attention away from pain or anxiety by distracting the listener with comforting music
- Provide a musical stimulus for rhythmic breathing
- Offer a rhythmic structure for systematic release of body tension
- Cue positive visual imagery
- Condition a deep relaxation response
- Change mood

For more information review April 2016 presentation and materials.
3j. ROLE OF NUTRITION IN PAIN MANAGEMENT

What we eat plays a role in general health. There are also connections with specific pain conditions and dietary management.

Key points of the presentation included:

- Start with a whole-food mostly plant-based diet
- Consider eliminating gluten and dairy in people with systemic pain, fatigue or auto-immune related pain
- Avoid reductionist mentality – cultivate a lifestyle that eats the rainbow rather than focusing on a few specific foods
- Tend your inner garden – use antibiotics and other medications as directed
- Pharmacology focuses on the downstream consequences of inflammation
- Inflammation can be dampened by avoiding exposure to triggers and modulating inflammatory mediators with lifestyle, diet, and nutraceuticals
- Create a physiologic bias toward wellness through a nutrient-rich diet

For more information review June 2016 presentation and materials.
3k. PEDIATRIC NON-PHARMACOLOGIC METHODS

The below interventions are approaches to the management of pain and painful procedures in pediatric patients which promote the right of the child and family to be fully involved in the minimizing of pain. Allowing parents and/or family members to act as positive assistants rather than negative restraints helps to reduce stress in both children and parents and minimizes the pain experience.

Points to Practice

• Taking into consideration children’s different responses to distraction interventions based on their developmental stage, maturity level, and age are proven effective with different age groups.
• Every child is different. Not every technique is going to work for every child.
• Assemble a distraction box for pediatric patients. For example, purchase inexpensive dollar items from stores or online.

Infants

• Non-nutritive Sucking – Use of a pacifier to encourage infant sucking behaviors is found to stimulate the orotactile and receptors to decrease cry durations and heart rate.
• Skin to Skin Contact – With the mother (kangaroo care), where the infant is positioned on the mother's exposed chest.
• Rocking and Holding – Parent, family or caregiver.
• Swaddling – Calming technique where the infant is wrapped with its extremities close to their trunk to prevent him/her from moving around excessively. Not a restraint but a comfort measure effective for patients up to 6 months of age.
• Rattles and bubbles

Toddlers and Preschoolers

• Age appropriate information
• Opportunities to ask questions
• Medical play
• Bubbles
• Colorful and light up toys
• “Seek and Find” books
• Singing and/or music
• Movies and tablets

School-Aged

• Age appropriate information, understand cause and effect
• Providing choices (e.g., sit or lie down, which hand)
• Blowing bubbles
• Singing and/or music
• Movies and tablets
• Squeezing balls
• Electronic devices

Adolescents

• Ensure privacy
• Age appropriate information
• Choices
• Squeeze balls
• Electronic devices
• Movies and tablets
• Music and/or headphones
• Deep breathing and guided imagery

Talk with a child life specialist to learn more.
31. POSITIONING AND EXERCISE

This section provides different effective tools to use with patients to assist in developing a plan to assist in preventing and helping to reduce the pain the patient is experiencing.

Pain-Stress Cycle
When movement of a body part leads to pain, there is a tendency to tighten muscles to stop moving that joint. Muscle spasms can occur, which can further tighten muscles and cause pain. Continually not using a joint may cause contracture (shortening) of muscles and ligaments, making less movement possible. This loss of motion can lead to depression and stress, which increases muscle tension and causes more pain. The additional pain can increase anxiety. And more anxiety = more tension = more pain … and so on through the cycle. Activities such as stress management techniques and pain relief measures can break this cycle and reduce pain and stress.

For more information review November 2015 “Empowering the Patient” presentation and materials.
3m. SPIRITUAL CARE

According to the World Health Organization (WHO), health is a dynamic state of complete physical, mental, spiritual, and social wellbeing and not merely the absence of disease or infirmities. Spiritual pain impacts physical pain and physical pain impacts spiritual pain. One cannot separate the two. This will explain the manner in which spiritual pain is connected to physical pain and tools and techniques on how to identify and manage these issues.

For more information review “Art of Pain Management” presentation from 2015 Pain Management Summit.
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CARE EXCELLENCE • JANUARY 2017
4a. PAIN ASSESSMENT TOOLS BACKGROUND

The Ascension Pain Management Initiative began with the opportunity to identify and standardize evidence-based pain assessment tools for all patient populations across the care continuum. Prior to this initiative, Ascension ministries used over 20 different pain assessment tools that weren't always used for the identified patient population potentially resulting in an inadequate pain assessment.

An Ascension System Pain Management Team comprised of nurses, doctors, and pharmacists representing adult and pediatric as well as an expertise in pain management came together to select the 12 evidence-based pain assessment tools for all patient populations. The 12 evidence-based pain assessment tools were approved by the Chief Nursing Officers of Ascension in January 2015. Once the tools were approved, the Ascension legal team was engaged to provide the necessary copyright information.

The implementation of the 12 evidence-based pain assessment tools was a part of the 2016 Integrated Scorecard Goal created for the person/family steering committee recommendations that stated, “By the end of Q4-FY16, Ascension Health and its Ministry markets will adopt...evidence-based guidelines and assessment tools for pain”. Implementing evidence-based pain assessment tools impacted every electronic medical record system, paper documentation, policies and procedures, communication boards, patient pamphlets, and clinical education, which resulted in a large system change.

Ascension Care Excellence partnered with Ascension Information System and Clinical Information System associates to lead the organization through this change. These teams worked closely with the identified clinical project leads from each ministry to lead this large local change. While the local clinical lead partnered with the local teams that included information systems associates, education, policy and procedure and local leadership to ensure all groups were included.

E-learning modules, decision tree and job aides were created to support this implementation. E-learning modules document in addition to the decision tree and job aides are included in this guideline. Any reproduction of these scales must include the copyright information as provided.

The 12 standardized evidence-based pain assessment tools are considered the foundation for the pain management strategy. The goal is that anywhere a patient’s pain is assessed within Ascension the clinician will utilize the appropriate, standard, evidence based pain assessment tool.

Click here for the 12 pain assessment tools
4b. PAIN ASSESSMENT TOOLS DECISION TREE

The purpose of the Pain Assessment Tool Decision Tree is to provide clinicians with a process to determine what pain assessment tool is appropriate for their patient. This will help to provide a consistent use of the proper pain assessment tool and thereby improved patient pain assessment.

---

**Pain Assessment Tools Decision Tree**

**ANTICIPATE PAINFUL PROCEDURES**

- **START**
  - **Assume Pain Present**
  - Prevention now may decrease chronic pain later.

**WHEN IN DOUBT**

- **Trial an intervention**
- **Watch for changes in behavior and physiological indicators.**
- **Treat pain if pathology or therapy cause pain for most people.**

**SELF-REPORT: PATIENT’S DESCRIPTION OF PAIN**

- **Self Report?**
  - **Y**
    - **Labor?**
      - **Y**
        - **Labor Coping**
      - **N**
    - **N**
  - **N**
    - **Numbers?**
      - **Y**
        - **Numeric**
      - **N**
    - **Faces?**
      - **Y**
        - **FPS-R**
      - **N**

**OBJECTIVE BEHAVIORAL ASSESSMENT**

- **Nonneat**
  - **NPASS preferred - 300 days**
  - **NIPS babies -< 30 days**
- **Pediatric**
  - **101 Days - 3 years**
- **Adult**
  - **3rd & up**

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4b. PAIN ASSESSMENT TOOLS DECISION TREE, continued

**Senior Living Pain Assessment Tools Decision Tree**

**ANTICIPATE PAINFUL PROCEDURES**

**START**

- Procedure? Y → Assume Pain Present
  - Prevention now may decrease chronic pain later.

**WHEN IN DOUBT**

- Y: Trial an intervention
- Y: Watch for changes in behavior and physiological indicators.
- Y: Treat pain if pathology or therapy cause pain for most people.

**SELF-REPORT: PATIENT'S DESCRIPTION OF PAIN**

- Self Report? Y
  - Numbers? Y → Numeric
    - The most valid and reliable measure of pain existence and intensity.
  - Numbers? N
    - Faces? Y → FPS-R
  - Faces? N

**OBJECTIVE BEHAVIORAL ASSESSMENT**

- Age
  - Adult (20+ yr)
    - Critical Condition Y → CPOT
    - Dementia? Y → PAIN-AD
  - Dementia? N → CNPI
    - N

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4c. SELF-REPORT PAIN ASSESSMENT TOOLS

Since pain is subjective and not something a clinician can see a patient's self-report of pain is considered the gold standard. The two tools selected for a patient to self-report their pain level are the Numeric Pain Rating Scale and Faces Pain Scale-Revised (FPS-R).

**Numeric Pain Rating Scale**

This is the gold standard for obtaining a self-reported pain level. This scale may be used in any care setting for patients eight years and older who are able to self-report their pain and understand the numeric scale.

![Numeric Pain Rating Scale](image)

**How to use:**

- Ask the patient, “On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you've experienced, at this moment, what number represents your overall pain level?”
- Patient to select one whole value

**Scoring/Documentation:**

- Numeric has a range from 0 to 10 possible.
- Document score in medical record (this includes 0 for no pain).

**Interpretation:**

- 0 to 3 mild pain
- 4 to 6 moderate pain
- 7 to 10 severe pain
- Compare the patient's acceptable level of pain to the patient's current self-report of pain to determine level of intervention. This may include non-pharmacologic and pharmacologic interventions.
- Reasses patient per frequency of local pain policy.
4c. SELF-REPORT PAIN ASSESSMENT TOOLS, continued

**Faces Pain Scale-Revised (FPS-R)**

This self-report pain assessment tool can be used in all care settings, with patients four years and older who can recognize and understand faces.

![Faces Pain Scale-Revised](image)

**How to use:**
- Show patient faces scale.
- Explain the tool, “These faces show how much something can hurt.” Point to zero picture and state, “This one shows no pain.” Point to ten picture and state, “This one shows worst pain experienced.”
- Ask patient, “What face best represents your pain level right now?”

**Scoring/Documentation:**
- Faces Pain Scale-Revised has a range from 0 to 10 possible.
- Document score in medical record; this includes 0 for no pain.

**Interpretation:**
- 0 to 3 mild pain
- 4 to 6 moderate pain
- 7 to 10 severe pain
- Compare the patients acceptable level of pain to the patients current self-report of pain to determine level of intervention. This may include non-pharmacologic and pharmacologic interventions.
- Reassess patient per frequency of local pain policy.


Order code: Faces Tool_April 2016
## 4d. ASSUME PAIN PRESENT

Assuming pain is present is using clinical judgement to determine that a patient could be experiencing pain. This is not a substitute assessment but a culmination of the total assessment. Assuming pain is present is used with patients who are unable to self-report their pain. Examples of patient populations include, but are not limited to:

- Infants/preverbal toddlers
- Older adults with advanced dementia or delirium
- Impaired level of consciousness
- Critically ill patients
- Mechanically ventilated, sedated, and paralyzed patients
- Patients at end of life
- Create a physiologic bias toward wellness through a nutrient-rich diet

### HOW TO USE:

- Determine if the patient is able to self-report
- If the patient is unable to self-report determine if there is an appropriate behavior based assessment tool
- If no tool is appropriate then assess if there are conditions present that predispose the patient to pain such as:
  - Presence of pathologic condition(s) or procedure(s) that usually cause pain. Many disease states cause pain. Review your patient’s medical history to identify potential causes of pain. It is also important to treat pain prior to wound care, rehabilitation activities, or invasive procedures.
  - Patient exhibits behaviors that may be indicative of pain. Behavioral assessment scales can be used, however, the behaviors listed may or may not be specific to pain for an individual patient.
  - Parent, family member, or others close to the patient report possible indicators of pain (proxy pain rating).
- Provide preemptive analgesics and non-pharmacologic strategies prior to pain producing procedures or activities.

### DOCUMENTATION:

- Document assume pain present (yes or no)
- If yes, add comments why pain is assumed present such as behaviors observed, procedures or therapies.
4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS

While a patient’s self-report of pain is considered the gold standard there are many instances in which a patient is unable to self-report their pain. There are nine behavior based tools selected to represent the entire patient population that is unable to self-report.

<table>
<thead>
<tr>
<th>The nine tools are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Neonatal Infant Pain Scale (NIPS)</td>
</tr>
<tr>
<td>• Neonatal Pain Agitation Sedation Scale (NPASS)</td>
</tr>
<tr>
<td>• Face, legs, activity, cry and Consolability (FLACC)</td>
</tr>
<tr>
<td>• Revised face, legs, activity, cry and Consolability (R-FLACC)</td>
</tr>
<tr>
<td>• Comfort Behavior (Comfort B)</td>
</tr>
<tr>
<td>• Checklist of Nonverbal Pain Indicators (CNPI)</td>
</tr>
<tr>
<td>• Critical Care Pain Observation Tool (CPOT)</td>
</tr>
<tr>
<td>• Pain Assessment in Advanced Dementia (PAIN-AD)</td>
</tr>
<tr>
<td>• Coping with Labor Algorithm</td>
</tr>
</tbody>
</table>
### NIPS: Neonatal Infant Pain Scale

Behavior observation pain assessment tool indicated for use with full term newborn to one year of age. Primarily used in OB, pediatric non-ICU areas, ED, pediatric pre-op and post-op surgery.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>SCORING DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FACIAL EXPRESSION</strong></td>
<td>Relaxed Muscles</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Restful face, neutral expression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grimace</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression - nose, mouth and brow)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td><strong>CRY</strong></td>
<td>No Cry</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Quiet, not crying</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Whimper</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mild moaning, intermittent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vigorous Cry</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Loud scream; rising, shrill, continuous</td>
<td></td>
</tr>
<tr>
<td><strong>BREATHING PATTERNS</strong></td>
<td>Relaxed</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Usual pattern for this infant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Change in Breathing</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Indrawing, irregular, faster than usual; gagging; breath holding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td><strong>ARMS</strong></td>
<td>Relaxed/Restrained</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No muscular rigidity; occasional random movements of arms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flexed/Extended</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tense, straight arms; rigid and/or rapid extension, flexion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td><strong>LEGs</strong></td>
<td>Relaxed/Restrained</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>No muscular rigidity; occasional random leg movements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Flexed/Extended</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Tense, straight legs; rigid and/or rapid extension, flexion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td><strong>STATE OF AROUSAL</strong></td>
<td>Sleeping/Awake</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Quiet, peaceful sleeping or alert random leg movement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fussy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Alert, restless, and thrashing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL NIPS SCORE</strong></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

How to use:
- Observe the infant for one minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

Scoring/Documentation:
- Add the scores from the 6 individual behavior areas to generate a total NIPS score.
- NIPS has a range from 0 to 7 possible.
- Document the total NIPS score in the medical record.

Interpretation:
- Does not provide pain intensity rating
- Any score greater than 2 indicates the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total NIPS score remains >2 consider pharmacologic intervention.
4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS, continued

### NPASS: Neonatal Pain, Agitation & Sedation Scale

Behavior observation pain assessment and sedation tool should be used with premature neonates to 100 days of life. This tool is primarily used in the pediatric pre and post-operative area, NICU, PICU and home care. 100 days of life is calculated from date of birth.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>SEDATION SCORING</th>
<th>SEDATION</th>
<th>NORMAL/PAIN</th>
<th>PAIN/AGITATION</th>
<th>PAIN/AGITATION SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying Irritability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-2</td>
<td>No cry with painful stimuli</td>
<td>Moans or cries minimally with painful stimuli</td>
<td>Appropriate crying</td>
<td>Irritable or crying at intervals</td>
</tr>
<tr>
<td></td>
<td>-1</td>
<td></td>
<td></td>
<td>Not irritable</td>
<td>Consolable</td>
</tr>
<tr>
<td></td>
<td>0/0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>Irritable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td>Not irritable</td>
<td></td>
</tr>
<tr>
<td>Behavior State</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No arousal to any stimuli; No spontaneous movement</td>
<td>Aroused minimally to stimuli; Little spontaneous movement</td>
<td>Appropriate for gestational age</td>
<td>Restless, squirming; Awakens frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial Expression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mouth is lax; No expression</td>
<td>Minimal expression with stimuli</td>
<td>Relaxed appropriate</td>
<td>Any pain expression, intermittent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities Tone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No grasp reflex; Flaccid tone</td>
<td>Weak grasp reflex; decreased muscle tone</td>
<td>Relaxed hands and feet</td>
<td>Normal tone</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs HR, RR, BP, SaO₂</td>
<td></td>
<td>No variability with stimuli; Hypoventilation or apnea</td>
<td>Less than 10% variability from baseline with stimuli</td>
<td>Within baseline or normal for gestational age</td>
<td>Increase 10-20% from baseline; SaO₂, 76-85% with stimulation – quick increase</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gestation/Corrected age</th>
<th>N/A</th>
</tr>
</thead>
</table>

**TOTAL SEDATION SCORE**  
/-10

**TOTAL PAIN/AGITATION SCORE**  
/13

**Premature Pain Assessment**

- +3 if less than 28 weeks gestation/corrected age
- +2 if less than 28 - 31 weeks gestation/corrected age
- +1 if less than 32 - 35 weeks gestation/corrected age


4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS, continued

NPASS: Neonatal Pain, Agitation & Sedation Scale
Order code: NPASS Tool April 2016

<table>
<thead>
<tr>
<th>How to Use</th>
<th>SEDATION</th>
<th>PAIN/AGITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sedation does not need to be assessed/scored with every pain assessment</td>
<td>Observe the infant for a minute before selecting a score for each behavior.</td>
</tr>
<tr>
<td></td>
<td>Observe the infant for a minute before selecting a score for each behavior.</td>
<td>Select only one numeric value per behavior.</td>
</tr>
<tr>
<td></td>
<td>Select only one numeric value per behavior.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scoring/Documentation</th>
<th>SEDATION</th>
<th>PAIN/AGITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sedation scores are negative scores only</td>
<td>Pain/Agitation scores are positive scores only</td>
</tr>
<tr>
<td></td>
<td>Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age)</td>
<td>Determine if scoring needs to be adjusted based on the patient’s gestational age. See Premature Pain Assessment criteria.</td>
</tr>
<tr>
<td></td>
<td>NPASS Sedation total score has a range from 0 to -10 possible.</td>
<td>Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score.</td>
</tr>
<tr>
<td></td>
<td>Document total NPASS Sedation score in the medical record.</td>
<td>Document the total NPASS Pain/Agitation score in the medical record.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interpretation</th>
<th>SEDATION</th>
<th>PAIN/AGITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Desired levels of sedation vary according to the situation.</td>
<td>Does not provide pain intensity rating.</td>
</tr>
<tr>
<td></td>
<td>Discuss and determine sedation goal with provider.</td>
<td>Any score greater than 3 indicates the possibility of the presence of pain in the infant</td>
</tr>
<tr>
<td></td>
<td>“Deep sedation”: goal score of -10 to -5</td>
<td>Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological).</td>
</tr>
<tr>
<td></td>
<td>Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea</td>
<td>Reassess patient per frequency of local pain policy.</td>
</tr>
<tr>
<td></td>
<td>“Light sedation”: goal score of -5 to -2</td>
<td>If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.</td>
</tr>
<tr>
<td></td>
<td>Reassess patient per frequency in local sedation policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A negative score without the administration of opioids/ sedatives may indicate:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The premature infant’s response to prolonged or persistent pain/stress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neurologic depression, sepsis, or other pathology</td>
<td></td>
</tr>
</tbody>
</table>

Paralysis/Neuromuscular blockade

- It is impossible to evaluate behaviorally a paralyzed infant for pain.
- Infants will usually have a sedation score of -10.
- Increases in heart rate and blood pressure at rest or with stimulation may be the only indicator for a need of more analgesia.
4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS, continued

**FLACC: Face, legs, activity, cry and consolability**

Behavior observation pain assessment tool indicated for use with infants 2 months to 18 years of age who are unable to self-report their pain. This tool is used primarily in pediatric non-ICU areas, ED, pediatric pre-op and post-op surgery, and home care.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>SCORING DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACE</td>
<td>No particular expression or smile</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Frequent to constant quivering chin, clenched jaw</td>
<td>2</td>
</tr>
<tr>
<td>LEGS</td>
<td>Normal position or relaxed</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Uneasy, restless, tense</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Kicking, or legs drawn up</td>
<td>2</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>Lying quietly, normal position moves easily</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Squirming, shifting back and forth, tense</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Arched, rigid or jerking</td>
<td>2</td>
</tr>
<tr>
<td>CRY</td>
<td>No cry, (awake or asleep)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moans or whimpers; occasional complaint</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
<td>2</td>
</tr>
<tr>
<td>CONSOLABILITY</td>
<td>Content, relaxed</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Reassured by occasional touching hugging or being talked to, distractable</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Difficulty to console or comfort</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL FLACC SCORE /10**


**How to use:**
- Observe the patient for a minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

**Scoring/Documentation:**
- Add the scores from the 5 individual behavior areas to generate a total FLACC score.
- FLACC has a range from 0 to 10 possible.
- Document total FLACC in the medical record.

**Interpretation:**
- Does not provide pain intensity rating
- Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total FLACC score remains consistent or higher consider pharmacologic intervention.
4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS, continued

**R-FLACC: Revised face, legs, activity, cry and consolability**

Behavior observation pain assessment tool indicated for use with infants 2 months to 18 years of age with a cognitive disability and is unable to self-report their pain. Used primarily in pediatric non-ICU areas, ED, pediatric pre-op and post-op surgery, PICU and home care.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>SCORING DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FACE</td>
<td>No particular expression or smile</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Occasional grimace or frown, withdrawn, disinterested, sad appears worried</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Frequent to constant quivering chin, clenched jaw, distressed looking face, expression of fright/panic</td>
<td>2</td>
</tr>
<tr>
<td>LEGS</td>
<td>Normal position or relaxed, usual tone &amp; motion to limbs</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Uneasy, restless, tense, occasional tremors</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Kicking, or legs drawn up, marked increase in spasticity, constant tremors, jerking</td>
<td>2</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>Lying quietly, normal positions move easily, regular, rhythmic respirations</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Squirming, shifting back and forth, tense, tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting</td>
<td>2</td>
</tr>
<tr>
<td>CRY</td>
<td>No cry, (awake or asleep)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Moans or whimpers; occasional complaint, occasional verbal outbursts, and/or grunting</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting</td>
<td>2</td>
</tr>
<tr>
<td>CONSOLABILITY</td>
<td>Content, relaxed</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Reassured by occasional touching hugging or being talked to, distractable</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Difficulty to console or comfort, pushing caregiver away, resisting care or comfort measures</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL R-FLACC SCORE /10**

**Interpretation:**
- Does not provide pain intensity rating
- Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions. Partner with patient's caregivers to identify appropriate interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total R-FLACC score remains consistent or higher consider pharmacologic intervention.

**Order code:** rFLACC Tool_April 2016
### COMFORT B: COMFORT Behavior

Behavior observation pain assessment and sedation tool indicated for use with neonates greater than 100 days of life to 18 years of age with a cognitive disability and is unable to self-report their pain, used primarily in NICU and PICU.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>SCORING DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALERTNESS</strong></td>
<td>Deep asleep (eyes closed, no response to change in environment)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Lightly asleep (eyes mostly closed, occasional response)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Drowsy (child closes his/her eyes frequently, less responsive to environment)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Awake and alert (child responsive to environment)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Awake and hyper-alert (exaggerated responses to environmental stimuli)</td>
<td>5</td>
</tr>
<tr>
<td><strong>CALMNESS/AGITATION</strong></td>
<td>Calm (child appears serene and tranquil)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Slightly anxious (child shows slight anxiety)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Anxious (child appears agitated but remains in control)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Very anxious (child appears very agitated, just able to control)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Panicky (severe distress with loss of control)</td>
<td>5</td>
</tr>
<tr>
<td><strong>RESPIRATORY RESPONSE</strong> (Score only in mechanically ventilated children)</td>
<td>No spontaneous respiration</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Spontaneous and ventilator respiration</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Restlessness or resistance to ventilator</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Actively breathes against ventilator or coughs regularly</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Fight ventilator</td>
<td>5</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td>Quietly breathing, no crying sounds</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occasional sobbing or moaning</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Whining (monotonous sound)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Crying</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Screaming or shrieking</td>
<td>5</td>
</tr>
<tr>
<td><strong>CRYING</strong> (Score only in spontaneously breathing children)</td>
<td>No movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Occasional (three or fewer) slight movements</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Frequent (more than three) slight movements</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Vigorous movements limited to extremities</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Vigorous movements including torso and head</td>
<td>5</td>
</tr>
<tr>
<td><strong>PHYSICAL MOVEMENT</strong></td>
<td>Muscles totally relaxed, no muscle movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Reduced muscle tone, less resistance than normal</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Normal muscle tone</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Increased muscle tone and flexion of fingers and toes</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Extreme muscle rigidity and flexion of fingers and toes</td>
<td>5</td>
</tr>
<tr>
<td><strong>MUSCLE TONE</strong> (Assess last)</td>
<td>Facial muscles totally relaxed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Normal facial tone</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Tension evident in some facial muscles (not sustained)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Tension evident throughout facial muscles (sustained)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Facial muscles contorted and grimacing</td>
<td>5</td>
</tr>
<tr>
<td><strong>FACIAL TENSION</strong></td>
<td>Facial muscles totally relaxed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Normal facial tone</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Tension evident in some facial muscles (not sustained)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Tension evident throughout facial muscles (sustained)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Facial muscles contorted and grimacing</td>
<td>5</td>
</tr>
</tbody>
</table>

**TOTAL COMFORT B SCORE** /30
4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS, continued

**COMFORT B: COMFORT Behavior**

Order code: COMFORT-B Tool, April 2016

**How to use:**
- Observe the patient for two minutes before selecting a score for each behavior.
- Select only one numeric value per behavior.
- Muscle tone should be assessed last as this requires active intervention by the clinician and can alter the other behavior responses.
- If the patient is ventilated assess for respiratory response. If the patient is not ventilated assess for crying.

**Scoring/Documentation**
- Add the scores from the 6 individual behavior areas to generate a total COMFORT B score.
- COMFORT B has a range from 6 to 30 possible.
- Document the highest numeric value behavior observed during the two minutes and the total COMFORT B score in the medical record.

**Interpretation:**
- **Pain:**
  - Does not provide pain intensity rating
  - Any score greater than or equal to 17 indicates the possibility of the presence of pain in the patient:
    - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
    - Re-assess patient per frequency of local pain policy.
    - If upon reassessment the total COMFORT B score remains consistent or higher consider pharmacologic intervention.
- **Sedation:**
  - Discuss patient goal with provider to determine sedation strategy:
    - A score of 6 to 10 indicates over sedation
    - A score of 11 to 23 indicates moderate sedation
    - A score of 24 to 30 indicates under sedation


CCC Ref: Reprinted from International Journal of Nursing Studies 51(6), Ambuel, B; Andersen, R., and Jylli, L., Cultural adaptation of patient and observational outcome measures: A methodological example using the COMFORT behavioral rating scale, 934-19, 2013. Reproduced with permission of copyright holder.

CCC Ref: Reprinted from Peiatr Crit Care Med 6 (1), Ista, E., Van Dijk, M., Tibboel, D., and de Hoog, M., Assessment of sedation levels in pediatric intensive care patients can be improved using the COMFORT “behavior” scale, 58-63, 2005. Reproduced with permission from copyright holder.

CNPI: Checklist of Nonverbal Pain Indicators

Behavior observation pain assessment tool indicated for use with adults 18 years of age and up with a cognitive disability and is unable to self-report their pain. This tool is used primarily in adult non-intensive care settings, Senior Living and home care.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>WITH MOVEMENT</th>
<th>AT REST</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = NOT OBSERVED</td>
<td>1 = OBSERVED WITH MOVEMENT AND/OR AT REST</td>
<td></td>
</tr>
<tr>
<td>1. Vocal complaints; nonverbal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Sighs, gasps, moans, groans, cries)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Facial Grimaces/Wincences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Bracing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Clutching or holding onto furniture, equipment, or affected area during movement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Restlessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Rubbing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Massaging affected area)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Vocal complaints; verbal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Words expressing discomfort or pain [e.g., “ouch,” “that hurts”]; cursing during movement; exclamations of protest [e.g., “stop,” “that’s enough!”])</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUBTOTAL SCORES**

**TOTAL CNPI SCORE (ADD BOTH SUB TOTALS) /12**

---

**How to use:**
- Observe the patient for a minute at both rest and during movement before selecting a score for each behavior.
- Select only one numeric value per observed behavior with movement and at rest.

**Scoring/Documentation:**
- Add the scores from the 6 individual behavior areas of at rest and with movement to generate a total CNPI score.
- CNPI has a range from 0 to 12 possible.
- Document total CNPI score in the medical record.

**Interpretation:**
- Does not provide pain intensity rating
- Any score between 1 and 12 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions. Partner with patient's caregivers to determine appropriate interventions.
  - Re-assess patient per frequency of local pain policy.
- If upon reassessment the total CNPI score remains consistent or higher consider pharmacologic intervention.
### CPOT: Critical-Care Pain Observation Tool

Behavior observation pain assessment tool indicated for use with adult patients 18 years of age and older who is unable to self-report their pain, and is used primarily in the Adult ICU setting and home care.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>SCORING DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial expressions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed, neutral</td>
<td>No muscle tension observed</td>
<td>0</td>
</tr>
<tr>
<td>Tense</td>
<td>Presence of frowning, brow lowering, orbit tightening and levator contraction, or any other change (e.g., opening eyes or tearing during nociceptive procedures)</td>
<td>1</td>
</tr>
<tr>
<td>Grimacing</td>
<td>All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)</td>
<td>2</td>
</tr>
<tr>
<td>Body movements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of movements or normal position</td>
<td>Does not move at all (doesn’t necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)</td>
<td>0</td>
</tr>
<tr>
<td>Protection</td>
<td>Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements</td>
<td>1</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed</td>
<td>2</td>
</tr>
<tr>
<td>Compliance with the ventilator (intubated patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerating ventilator or movement</td>
<td>Alarms not activated, easy ventilation</td>
<td>0</td>
</tr>
<tr>
<td>Coughing but tolerating</td>
<td>Coughing, alarms may be activated but stop spontaneously</td>
<td>1</td>
</tr>
<tr>
<td>Fighting ventilator</td>
<td>Asynchrony: blocking ventilation, alarms frequently activated</td>
<td>2</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocalization (extubated patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking in normal tone or no sound</td>
<td>Talking in normal tone or no sound</td>
<td>0</td>
</tr>
<tr>
<td>Sighing, moaning</td>
<td>Sighing, moaning</td>
<td>1</td>
</tr>
<tr>
<td>Crying out, sobbing</td>
<td>Crying out, sobbing</td>
<td>2</td>
</tr>
<tr>
<td>Muscle tension (Assess last) Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed</td>
<td>No resistance to passive movements</td>
<td>0</td>
</tr>
<tr>
<td>Tense, rigid</td>
<td>Resistance to passive movements</td>
<td>1</td>
</tr>
<tr>
<td>Very tense or rigid</td>
<td>Strong resistance to passive movements, incapacity to complete them</td>
<td>2</td>
</tr>
</tbody>
</table>

**TOTAL CPOT SCORE** 8
CPOT: Critical-Care Pain Observation Tool

How to use:
- Observe the patient for a minute before selecting a score for each behavior.
- Muscle tension should be assessed last as this requires active intervention by the clinician and can alter the other behavior responses.
- Select only one numeric value per behavior.
- If the patient is ventilated assess for compliance with the ventilator. If the patient is not ventilated assess for vocalization.

Scoring/Documentation:
- Add the scores from the 5 individual behavior areas to generate a total CPOT score.
- CPOT has a range from 0 to 8 possible.
- Document the highest numeric value behavior observed during the minute and the total CPOT score in the medical record.

Interpretation:
- Does not provide pain intensity rating
- Any score between 1-8 indicates the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total CPOT score remains consistent or higher consider pharmacologic intervention.


CCC Ref: Reprinted from Critical Care Nurse, 33 (3), Stites, M., Observational Pain Scales in Critically Ill Adults, 68-79, 2013. Reproduced with permission from copyright holder.
**PAIN-AD: Pain Assessment in Advanced Dementia**

Behavior observation pain assessment tool indicated for use with adult patients 18 years of age and older, with a diagnosis of dementia and is unable to self-report their pain. This tool is used primarily in ED, adult pre-op and post-op surgery, adult ICU, Adult non-ICU, Senior Living, home care and the provider’s office.

<table>
<thead>
<tr>
<th>BEHAVIOR INDICATORS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing Independent of vocalization</td>
<td>Normal</td>
<td>• Occasional labored breathing</td>
<td>• Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Short period of hyperventilation</td>
<td>• Long period of hyperventilation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>• Occasional moan or groan</td>
<td>• Repeated troubled calling out</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low-level speech with a negative or disapproving quality</td>
<td>• Loud moaning or groaning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smiling or inexpressive</td>
<td>• Sad</td>
<td>• Rigid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Frightened</td>
<td>• Fists clenched</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Frown</td>
<td>• Knees pulled up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Pulling or pushing away</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Striking out</td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>• Tense</td>
<td>• Distracted or reassured by voice or touch</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Distressed pacing</td>
<td>• Unable to console, distract, or reassure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fidgeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>• Distracted or reassured by voice or touch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL PAIN-AD SCORE /10**

How to use:
- Observe the patient for a minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

**Scoring/Documentation:**
- Add the scores from the 5 individual behavior areas to generate a total PAIN-AD score.
- PAIN-AD has a range from 0 to 10 possible.
- Document total PAIN-AD in the medical record.

**Interpretation:**
- Does not provide pain intensity rating
- Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total PAIN-AD score remains consistent or higher consider pharmacologic intervention.
It is expected that laboring women will experience pain. Therefore asking the patient their pain level is frustrating and confusing. The coping with Labor Algorithm focuses on how laboring women are coping via self-reporting and observation. This is to be used on laboring women only primarily in the OB area.

Clues you might see if woman is coping:
- States she is coping
- Rhythmic activity during contraction (Rocking, swaying)
- Focused inward
- Rhythmic breathing
- Able to relax between contractions
- Vocalization (moaning, counting, chanting)

Physiologic, Natural process of labor

Follow:
- Unit
- Service line
- Hospital

Guidelines/standards for pharmacologic intervention

Patient desires pharmacological intervention

Coping

Observe for clues on admission and throughout labor.
Assessment per protocol:
Ask: “How are you coping with your labor?”
• Every shift • PRN • At signs of change.

Clues you might see if woman is NOT coping:
- States she is not coping
- Crying (May see with self-hypnosis)
- Sweaty
- Tremulous voice
- Thrashing, wincing, writhing

Emotional/Psychosocial

The nurse should consider:
- Patient’s life
- Sexual abuse
- Fear
- Stress
- Interpersonal dynamics

Offer social work consult

Reassessment

Interventions as to what would give best relief and is indicated (what does the patient desire):
- Tub/bathtub/shower [S]
- Hot pack/cold pack [*]
- Water injections [S]
- Massage/pressure [*]
- Movement/ambulation/position changes [S]
- Birth ball [*]
- Focus points [*]
- Breathing techniques [*]
- Acupuncture [S]
- Self-Hypnosis [S]
- TENS [*]

One-on-One Support [S]
Doula [S]
Midwifery Care being “With Woman” [S]

The nurse should decide:
- Mood [*]
- Lighting [*]
- Music [*]
- Fragrance [*]
- TV/Movie [*]
- Temperature [*]
- Whispering voices [*]

Physical Environment

Appropriate changes to environment PRN [S]

Clues you might see if woman is coping:
- Patient desires non-pharmacological intervention

Not Coping

Not Coping

Patient desires non-pharmacological intervention

Not Coping (May be seen in transition)

Observe for clues on admission and throughout labor.
Assessment per protocol:
Ask: “How are you coping with your labor?”
• Every shift • PRN • At signs of change.

Clues you might see if woman is coping:
- States she is coping
-Rhythmic activity during contraction (Rocking, swaying)
- Focused inward
- Rhythmic breathing
- Able to relax between contractions
- Vocalization (moaning, counting, chanting)

Physiologic, Natural process of labor

Follow:
- Unit
- Service line
- Hospital

Guidelines/standards for pharmacologic intervention

Patient desires pharmacological intervention

Coping

Observe for clues on admission and throughout labor.
Assessment per protocol:
Ask: “How are you coping with your labor?”
• Every shift • PRN • At signs of change.

Clues you might see if woman is NOT coping:
- States she is not coping
- Crying (May see with self-hypnosis)
- Sweaty
- Tremulous voice
- Thrashing, wincing, writhing

Emotional/Psychosocial

The nurse should consider:
- Patient’s life
- Sexual abuse
- Fear
- Stress
- Interpersonal dynamics

Offer social work consult

Reassessment

Interventions as to what would give best relief and is indicated (what does the patient desire):
- Tub/bathtub/shower [S]
- Hot pack/cold pack [*]
- Water injections [S]
- Massage/pressure [*]
- Movement/ambulation/position changes [S]
- Birth ball [*]
- Focus points [*]
- Breathing techniques [*]
- Acupuncture [S]
- Self-Hypnosis [S]
- TENS [*]

One-on-One Support [S]
Doula [S]
Midwifery Care being “With Woman” [S]

The nurse should decide:
- Mood [*]
- Lighting [*]
- Music [*]
- Fragrance [*]
- TV/Movie [*]
- Temperature [*]
- Whispering voices [*]

Physical Environment

Appropriate changes to environment PRN [S]

Clues you might see if woman is coping:
- Patient desires non-pharmacological intervention

Not Coping

Not Coping (May be seen in transition)

Observe for clues on admission and throughout labor.
Assessment per protocol:
Ask: “How are you coping with your labor?”
• Every shift • PRN • At signs of change.

Clues you might see if woman is NOT coping:
- States she is not coping
- Crying (May see with self-hypnosis)
- Sweaty
- Tremulous voice
- Thrashing, wincing, writhing

Emotional/Psychosocial

The nurse should consider:
- Patient’s life
- Sexual abuse
- Fear
- Stress
- Interpersonal dynamics

Offer social work consult

Reassessment

Interventions as to what would give best relief and is indicated (what does the patient desire):
- Tub/bathtub/shower [S]
- Hot pack/cold pack [*]
- Water injections [S]
- Massage/pressure [*]
- Movement/ambulation/position changes [S]
- Birth ball [*]
- Focus points [*]
- Breathing techniques [*]
- Acupuncture [S]
- Self-Hypnosis [S]
- TENS [*]

One-on-One Support [S]
Doula [S]
Midwifery Care being “With Woman” [S]

The nurse should decide:
- Mood [*]
- Lighting [*]
- Music [*]
- Fragrance [*]
- TV/Movie [*]
- Temperature [*]
- Whispering voices [*]
4e. BEHAVIOR BASED PAIN ASSESSMENT TOOLS, continued

Coping with Labor Algorithm\textsuperscript{v2}

Order code: Coping Tool, April 2016

**How to use:** There are 2 areas to assess:

- Woman’s self-report of coping: Ask patient, “How are you coping with your labor?”
- Clinician observation of coping: Observe the woman for visual clues demonstrating coping or not coping (as noted on previous page)

**Scoring/Documentation:**

- Document the woman’s self-report of coping: “states coping” or “states not coping”
- Document the clinician observation of coping: “demonstrates/observed coping behavior” or “demonstrates/observed non-coping behavior”
- Document all interventions in the medical record.

**Interpretation:**

- If the clinician identifies that a woman is not coping there are 3 levels of interventions available, physiologic, physical environment and emotional/psychosocial (as noted on previous page).
- Obtain patient’s preferences, demonstrated behaviors and available treatment options to determine potential interventions.
- There is no limit to the number of interventions to utilize, nor a requirement to select from each category. It is up to the needs and requests of the laboring woman.
- Re-assess patient per frequency of local pain policy.


CCC Ref: Reprinted from Nursing for Women’s Health, 12[5], Gulliver, B., Fisher, J., & Roberts, L., A new way to assess pain in laboring women: Replacing the rating scale with a “coping” algorithm, 404-408, 2008. Reproduced with permission from copyright holder.

CCC Ref: Reprinted from Comprehensive Accreditation Manual for Hospitals, Oakbrook Terrace, IL: Author, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), 2008. Reproduced with permission from copyright holder.


CCC Ref: Reprinted from Birth, 27[4], Niven, C. & Murphy-Black, T., Memory for labor pain: A review of the literature, 244-253, 2000. Reproduced with permission from copyright holder.

4f. CONCLUSION

The three high level strategies of pain management that include best practice recommendations, integrative therapies and standard, evidence based pain assessment tools will improve how we partner with patients to provide therapeutic pain management and thereby reducing the footprint that we contribute to the opioid crisis.

High reliability practices are a foundation for the development of the pain management guidelines. Some examples of how the concepts of highly reliable care are listed below.

- **Preoccupation with failure**
  - Safety is #1 priority in developing order sets
  - One pain management order set (increases the opportunity for consistent use of evidence-based pain management principles)
  - Pain assessment build
    - One standard build template that all followed (standardization)
    - Auto calculate to eliminate human error calculations
    - Auto calculate to only allow range available for that tool

- **Reluctance to Simplify**
  - Pain assessment tools
    - Number of tools (minimized to cover all patient populations)
    - Behavior based tools have varying result ranges. It is more important to have the evidence based tool versus consistent result ranges.
  - Order Sets: If pain “x” give “x” would be easy but evidenced based literature tells us this doesn’t work

- **Sensitivity to Operations**
  - One pain management order set reduces the build and maintenance time
  - Pain assessment tools: Only display what that unit’s patient population requires, i.e. NICU only sees pediatric tools and not adult

- **Commitment to Resilience**
  - Monitoring
    - Developed report to monitor Narcan administered over opioids administered to provide run rate
    - Extract over-sedation events from event reporting system

- **Deference to Expertise**
  - Team participants: Variety of clinicians, representing the care continuum
  - Utilized talent from external sites: CDC, TJC, APS, ASPMN, etc.
  - Pain assessment tools teach that only the patient can tell you their pain and to partner with care givers to understand behaviors of cognitively impaired patients

Ascension clinicians coming together as One Integrated Ministry and following the Principles of Highly Reliable Care led to the ability to create the Pain Management Guidelines for all patients across the care continuum.
APPENDIX A—FACTORS IN ADDITION TO PAIN INTENSITY THAT CAN INFLUENCE OPIOID DOSE REQUIREMENT⁷

<table>
<thead>
<tr>
<th>Factor</th>
<th>Considerations</th>
<th>Rational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Reduce initial opioid doses and establish longer dosing intervals for both older adults and the very young, such as neonates and infants, who have incomplete organ development.</td>
<td>Opioids are metabolized in the liver and excreted by the kidneys either unchanged or as metabolites. Some degree of renal insufficiency occurs as a result of normal aging, making older adults susceptible to drug effects and metabolite accumulation.</td>
</tr>
<tr>
<td>Quality of Pain</td>
<td>Elicit and listen to patient description of pain closely to determine type of pain and associated treatment.</td>
<td>The words patients use to describe their pain are helpful in determining the underlying pain mechanism and appropriate treatment. “Aching” or “throbbing” pain may indicate nociceptive pain, which is responsive to such analgesics as acetaminophen, non-steroidal anti-inflammatory drugs, local anesthetics, and opioids. “Burning” or “shooting” pain is associated with neuropathic pain, which is responsive to such analgesics as anticonvulsants, antidepressants, and local anesthetics.</td>
</tr>
<tr>
<td>Sedation Level</td>
<td>Obtain, document and utilize sedation level to determine safe opioid prescribing and administration.</td>
<td>Increased levels of sedation precede opioid-induced respiratory depression, making sedation assessment prior to and at peak effect time following opioid administration is essential. Opioid dose should be reduced whenever increased sedation is detected and monitoring of sedation level and respiratory status should be increased in frequency and intensity until sedation and respiratory status are normalized and stable.</td>
</tr>
<tr>
<td>Respiratory Status</td>
<td>Assess for respiratory disease such as COPD, Obstructive sleep apnea, etc.</td>
<td>All patients are at risk for opioid-induced respiratory depression; however, patients with pulmonary compromise, such as chronic obstructive pulmonary disease or obstructive sleep apnea, are at elevated risk. Initial and ongoing assessment of patient risk for opioid-induced respiratory depression helps to determine appropriate opioid dosing and level of monitoring.</td>
</tr>
</tbody>
</table>
APPENDIX A–FACTORS IN ADDITION TO PAIN INTENSITY THAT CAN INFLUENCE OPIOID DOSE REQUIREMENT

<table>
<thead>
<tr>
<th>Factor</th>
<th>Considerations</th>
<th>Rational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status</td>
<td>Patient's ability to achieve functional goals.</td>
<td>The goal of analgesic treatment is to improve the patient’s ability to achieve functional goals, such as ambulation and participation in physical therapy (PT). The patient’s functional goals and activity schedule are important considerations in determining opioid dose selection and timing of administration. There may be a need for higher doses prior to painful activities than at bedtime. Include efficacy of opioid treatment toward goal achievement in handoff reports for continuity of care.</td>
</tr>
<tr>
<td>Tolerance</td>
<td>Assess previous and current opioid use.</td>
<td>Opioid tolerance is the state of adaptation in which exposure to an opioid induces changes that result in diminution of one or more of the opioid’s effects over time, making assessment of previous and current opioid use prior to opioid administration essential. Patients receiving long-term opioid therapy may experience decreased analgesia and side effects due to the presence of opioid tolerance.</td>
</tr>
<tr>
<td>Drug-drug Interactions</td>
<td>Assess medication history to determine concomitant administration of other sedating medications.</td>
<td>When two drugs are given at the same, one drug may alter the effect of the other drug either by changing its effectiveness or increasing its adverse effects. Concomitant administration of other sedating drugs during opioid therapy increases the risk of respiratory depression.</td>
</tr>
<tr>
<td>Reaction/Response to Prior Opioid Treatment</td>
<td>Assess patient’s response to previous opioids.</td>
<td>Assessment prior to opioid treatment should include the patient’s response to previous opioids including analgesic efficacy and side effects. Many factors influence response to opioid analgesics. Changes in opioid or dose may be effective in patients who report a lack of efficacy or intolerable side effects with a previously prescribed opioid.</td>
</tr>
</tbody>
</table>
### APPENDIX A–FACTORS IN ADDITION TO PAIN INTENSITY THAT CAN INFLUENCE OPIOID DOSE REQUIREMENT,

<table>
<thead>
<tr>
<th>Factor</th>
<th>Considerations</th>
<th>Rational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical and Psychiatric Co-morbidities:</td>
<td>Assess presence, severity and treatment of co-morbidities.</td>
<td>Assessment prior to opioid administration should include the presence, severity, and treatment of co-morbidities. Physical co-morbidities can affect hepatic metabolism and renal excretion of opioids; psychiatric co-morbidities can affect how pain is perceived and expressed; drugs used to treat co-morbidities can act synergistically or in an additive manner to affect opioid analgesic efficacy and side effects.</td>
</tr>
<tr>
<td>Genitourinary Status</td>
<td>Assess for genitourinary problems.</td>
<td>Opioids can increase smooth muscle tone in the bladder, ureters, and sphincter, which can cause bladder spasms and urine retention. Urinary tract infections and stones can cause pain. Assessment of potential sources of pain and optimizing treatment with multimodal analgesia may help to improve analgesia with the lowest effective opioid dose.</td>
</tr>
<tr>
<td>Cardiovascular Status</td>
<td>Assess for cardiovascular problems.</td>
<td>Opioids can lower blood pressure by dilating peripheral arterioles and veins. Dehydration and hypotensive drugs can worsen postural hypotension. In addition to optimal hydration, multimodal analgesia strategies that allow the lowest effective opioid dose may be helpful in minimizing adverse cardiovascular effects.</td>
</tr>
<tr>
<td>Endocrine Status</td>
<td>Assess for endocrine problems.</td>
<td>MU opioid agonist can lower testosterone.</td>
</tr>
</tbody>
</table>
### APPENDIX B–INTERMOUNTAIN HEALTHCARE. (2014, AUGUST). PRIMARY CARE MANAGEMENT OF LOW BACK PAIN.28

#### (c) RED Flag evaluation and response

<table>
<thead>
<tr>
<th>Suspected condition and signs</th>
<th>Labs</th>
<th>Imaging (see page 6)</th>
<th>Referral</th>
</tr>
</thead>
</table>
| **Suspected cauda equina syndrome:**  
• New bowel or bladder dysfunction  
• Perineal numbness/saddle anesthesia  
• Persistent/increasing lower motor neuron weakness |                   | • For suspected cauda equina: spinal MRI*  
• For myelopathy/upper motor neuron changes: MRI* or CT, spine or brain | URGENT referral to ortho/neuro spine surgeon |
| **Myelopathy/upper motor neuron changes:**  
• New-onset Babinski or sustained clonus  
• New-onset gait or balance abnormalities  
• Upper motor neuron weakness |                   | • X-ray: anteroposterior (AP) and cone down, consider CT or MRI* if x-ray is nondiagnostic  
• X-ray: AP and cone down; repeat in 2 weeks if suspicion high  
• Consider MRI* if suspicion high | URGENT referral to ortho/neuro spine surgeon if imaging reveals fracture |
| **Recent trauma with suspected spinal fracture** |                   | • X-ray: anteroposterior (AP) and cone down, consider CT or MRI* if x-ray is nondiagnostic | URGENT referral to ortho/neuro spine surgeon |
| **Suspected compression fracture:** Osteoporosis or osteoporosis risk |                   | • X-ray: AP and cone down; repeat in 2 weeks if suspicion high  
• Consider MRI* if suspicion high | Referral to nonsurgical back specialist if imaging reveals compression fracture |
| **Suspected cancer:**  
• History of cancer, multiple cancer risk factors, or strong clinical suspicion | CBC, ESR, CRP     | • X-ray (evaluate in context with ESR)  
• If negative x-ray but strong suspicion remains: consider T1 weighted, noncontrasted spinal MRI* (full study w/contrast for abnormal areas) | URGENT referral to oncologist |
| **Suspected infection:** Immunocompromised patient, UTI, IV drug use, recent spinal procedure, or fever/chills in addition to pain with rest or at night | CBC, ESR, CRP     | • Consider MRI* with gadolinium or bone scan | URGENT referral may be needed, depending on type of infection |
| **Suspected spinal deformity or spondylolysis:** Age <20, pain with standing, walking, and extension (occurs more often in athletes and dancers) |                   | • Standing x-rays, 3 view, flexion, extension, plus cone down  
• Consider MRI* to identify spondylolysis represented by pedicle edema | Referral to sports medicine specialist, nonsurgical back specialist, or ortho/neuro spine surgeon if x-ray or MRI positive |
| **Suspected spondyloarthropathies:**  
• Ankylosing spondylitis (AS): at least 4 of the following: age of pain onset <40 years; insidious onset; improvement with exercise; no improvement with rest; pain at night (with improvement upon rising)  
• Reactive arthritis/Reiter’s Syndrome: recent history of genitourinary or gastrointestinal tract infection; acute onset; usually affecting lower joints; asymmetrically painful and swollen joints; weight loss; high temperatures  
• Spondyloarthritis associated with inflammatory bowel disease (IBD): abrupt onset; asymmetric, affecting lower limbs; generally subsides in 6–8 weeks; 10% develop chronic arthritis; other symptoms: urethritis, chronic skin lesions, dactylitis, enthesitis  
• Psoriatic arthritis: asymmetric, affecting distal joints; morning stiffness; pain accentuated by prolonged immobility, alleviated by physical activity, psoriatic lesions. | CBC, ESR, CRP, RF, anti-CCP, HLA B27 | • X-ray: lumbar spine and sacroiliac joint  
• Note: If clinical features lasting longer than 3 months strongly suggest AS despite negative radiographs of SI joint, consider close follow up and/or referral to rheumatologist. | Referral to rheumatologist |
# Appendix C – Wilda Tool

Permission for the use of the Wilda tool and modification by Patrice (Patti) Murray, DNP, ACHPN, RN-BC, Nurse Practitioner, AMITA HealthCare was given by Regina Fink, RN, PhD, FAAN, AOCN, University of Colorado Hospital, Denver.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Question</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Words</strong></td>
<td>Describe the pain</td>
<td>NEUROPATHIC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shooting, stabbing, sharp, burning, tingling,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOCIEPTIVE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tender, Achy, heavy, campy, squeezing, deep,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>miserable, intolerable,</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td>How much pain does the patient have</td>
<td>Numeric- 0-10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visual- faces or descriptor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Behavior Tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NPASS, FLACC—PABS-PPP</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Where is the pain</td>
<td>Extremity or body part</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>When did the pain start</td>
<td>Is the pain new or old?</td>
</tr>
<tr>
<td></td>
<td>When does the pain occur</td>
<td>How long does the pain last</td>
</tr>
<tr>
<td><strong>Aggravating</strong></td>
<td>What makes the pain worse</td>
<td>Examples-Coughing, sneezing, exercise, talking,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>walking</td>
</tr>
<tr>
<td><strong>Alleviating</strong></td>
<td>What makes the pain better</td>
<td>Examples-Ice, heat, rest, medication, quiet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What have you done in the past?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What treatments have helped?</td>
</tr>
<tr>
<td><strong>Associated</strong></td>
<td>What is associated with the pain</td>
<td>Nausea, Vomiting, diaphoresis, SOB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How far can you walk? How many hours of sleep</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>What is the pain stopping you from doing</td>
<td>Assess the level of functionality—What is the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>highest level of function expected</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital—CT&amp;DB, OOB/Ch., PT/OT, ADL, Eating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-patient-ADL - working</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOOLS- PPS, Karnofsky, ECOG</td>
</tr>
<tr>
<td><strong>Affect</strong></td>
<td>Are you feeling sad/depressed</td>
<td>Screen for depression—associated with Chronic</td>
</tr>
<tr>
<td></td>
<td>Are you feeling anxious</td>
<td>pain</td>
</tr>
<tr>
<td></td>
<td>Emotional response related to the pain</td>
<td>Screen for Anxiety—associated with acute pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Any patient may have both at the same time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What the pain means to the patient at that</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>Screen for Previous Opioid Use, Side Effects,</td>
<td>Nausea, vomiting, constipation, itching,</td>
</tr>
<tr>
<td></td>
<td>Sedation, Diversion, Goals of Care</td>
<td>sedation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diversion-Opioid risk assessment tool</td>
</tr>
</tbody>
</table>
APPENDIX D—PASERO OPIOID-INDUCED SEDATION SCALE (POSS)

Table 1.
Pasero Opioid-induced Sedation Scale (POSS) with Interventions*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Sleep, easy to arouse</td>
<td>Acceptable; no action necessary; may increase opioid dose if needed</td>
</tr>
<tr>
<td>1</td>
<td>Awake and alert</td>
<td>Acceptable; no action necessary; may increase opioid dose if needed</td>
</tr>
<tr>
<td>2</td>
<td>Slightly drowsy, easily aroused</td>
<td>Acceptable; no action necessary; may increase opioid dose if needed</td>
</tr>
<tr>
<td>3</td>
<td>Frequently drowsy, arousal, drifts off to sleep during conversation</td>
<td>Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%; or contact primary or anesthesia provider for order to decrease opioid dose; consider administering non-sedating, opioid-sparing non-opioids, such as acetaminophen and an NSAID, if not contraindicated; ask patient to take deep breaths every 15-30 minutes.</td>
</tr>
<tr>
<td>4</td>
<td>Somnolent, minimal or no response to verbal and physical stimulation</td>
<td>Unacceptable; stop opioid; consider administering naloxone; stay with patient, stimulate, and support respiration as indicated by patient status; call Rapid Response Team (Code Blue) if indicated; notify primary or anesthesia provider; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.</td>
</tr>
</tbody>
</table>

Pasero Opioid-Induced Sedation Scale (POSS) Copyright 1994, Chris Pasero. Our intellectual property counsel talked with Chris Pasero and they provided a copy of the blanket permission issued for the general public. See attached. Ascension is thus free to use the Scale as noted.

APPENDIX E—ASCENSION SYSTEM PAIN MANAGEMENT TEAM MEMBERS

Pain Management Team Member listing for the guideline document

APPENDIX F—PAIN MANAGEMENT REFERENCES AND RESOURCES:


APPENDIX F—PAIN MANAGEMENT REFERENCES AND RESOURCES, continued


APPENDIX F—PAIN MANAGEMENT REFERENCES AND RESOURCES, continued


APPENDIX F–PAIN MANAGEMENT REFERENCES AND RESOURCES, continued


APPENDIX F–PAIN MANAGEMENT REFERENCES AND RESOURCES, continued


APPENDIX F–PAIN MANAGEMENT REFERENCES AND RESOURCES, continued


Additional suggested reading:

