CAREPATHrx™
Specialty Pharmacy & Infusion Solutions

PAIN MANAGEMENT AND ASSESSMENT

Section: Nursing
Compliance: ACHC Infusion Pharmacy
ACHC Standards: N/A
URAC Standards: N/A
TJC Standards: LD.04.03.13 EP 3, PC.01.02.07 EP 1, 3, 4, 5, 6, 8; PC.02.03.01 EP 10
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Approved by: Kathleen Patrick, President 1/1/21, 5/1/21, 9/1/21, 5/1/22, 12/1/23, 1/1/24

I. POLICY

Pain management and assessment are identified as organizational priorities. Parenteral pain management and patient-controlled analgesia are administered via a continuous or intermittent infusion per physicians or authorized prescriber's orders. The clinician(s) who dispense opioid medications, administer pain medication, and conduct pain assessments, shall be knowledgeable of the indications, types of medications used, appropriate dosages, administration, side effects and complications associated with treatment. The organization provides staff with educational resources to improve pain assessment, pain management, and safe use of opioid medications, based on the needs of its patient population. The following guidelines will be followed when providing pain management.

All patients will be assessed for pain, including vascular access device (VAD) and subcutaneous infusion site pain. Each VAD assessment includes patient report of discomfort/pain. Each subcutaneous site assessment includes patient reports of burning or pain. Instruct the patient of the importance of immediately reporting any pain, burning, sensation changes, or pressure around VAD or subcutaneous sites.

II. PROCEDURES

A. All patients referred for Pain Management Therapy will meet the clinical criteria for patient admission. Documentation in the patient record will include review of:
    a. Appropriateness of medication and dose
    b. Effectiveness (patient's response to current pain management)
    c. Determining if all care/services are being provided
    d. Change in patient condition.

B. Circulatory access for pain management may include the use of an intravenous, subcutaneous, or indwelling spinal catheter. If the intravenous route is used, an indwelling, central venous catheter is preferred to assure consistent, uninterrupted pain relief. If the intraspinal route is used, an indwelling, permanent catheter is preferred.

C. The nurse shall administer and/or teach the patient and/or caregiver to administer medications for pain control, as appropriate.

D. The Nurse shall administer narcotics **but may only administer low dose anesthetic agents** used for the relief of pain according to state nurse practice acts.

E. **Low dose anesthetic agents WILL NOT be first dosed at home unless used in combination with an analysis agent such as Morphine in such a dose to minimize potential adverse reaction(s).** Patients receiving low dose anesthetic agents must be monitored for a minimum of 48 hours in the hospital prior to discharge home. If a patient converts from a narcotic to a low dose anesthetic agent, the required monitoring period is 24 hours.

F. Marcaine (BUPivicaine) will ONLY be administered epidurally in the home. Adverse effects related to intravenous administration make this route unsafe for the home setting.

G. The physician's order will reflect:

1. Name of the drug
2. Dose/concentration
3. Frequency of delivery (intermittent or continuous)
4. Route of administration
5. Titration or patient-controlled analgesia schedule. Ideally, a dose range will be obtained, allowing flexibility in managing the patient's pain.
6. Dose or rate can be safely increased in increments of 10-20% of the current rate. For the first 1-2 hours after a rate change, the patient should be monitored closely for adverse effects

H. The routine use of naloxone (Narcan) in the home is not recommended because:

1. Naloxone (Narcan) administration to physically dependent patients may precipitate an acute withdrawal.
2. If Naloxone (Narcan) is required, proper administration requires continued surveillance and monitoring by a health care professional. The nurse must stay with the patient at least ½ hour after administration to monitor response.

I. The nurse and pharmacist will assist the physician in converting the patient's pain medication from one route to another when appropriate.

J. All continuous infusions of pain medications shall be administered using an infusion device, such as an ambulatory PCA pump or an implanted pump.

K. The pain treatment plan is based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.

L. Patients are involved with the pain treatment plan through the development of realistic expectations and measurable goals understood by the patient, discussion of the objectives used to evaluate treatment progress, and education on pain management, treatment options, and the safe use of opioid and non-opioid medications when prescribed.

1. The treatment plan is assessed and updated based on:

   a. Ongoing assessment and reassessment of patient self-report of pain or objective measure of pain using a valid, reliable, developmentally appropriate pain assessment tool.
   b. Assessment of potential adverse effects.

c. Regular evaluation of infusion device function, number of injections and attempts, potential for patient manipulation.
d. Change in patient's condition.
e. The plan of care will be provided to the patient.

M. Nurse involvement with Pain Management involving Schedule II narcotics shall comply with all state and federal guidelines regarding dispensing, discarding, transporting and usage in the home. Patients and families are educated on the safe use, storage, and disposal of opioids when prescribed.

N. The clinicians involved in teaching and monitoring pain management of a patient may use the pain and sedation scale below. For pediatric patients, the Baker-Wong (faces) scale may be used.

O. Patient/Caregiver Teaching:

1. Administration of pain medication per provider order, including bolus technique as applicable, validated by return demonstration. Education includes administration steps, time, frequency, route, and dose.
2. Medication name, type, and reason for use
3. Signs and symptoms of complications and side effects and when to notify the agency and/or physician. Side effects of parenteral administration of pain medication include nausea, vomiting, increased sedation, constipation, respiratory depression. In addition, side effects of interspinal administration of pain medications include pruritis, urinary retention, tolerance catheter migration, meningitis. Subcutaneous administration side effects include pain, pressure, pruritus, rash, induration, erythema, swelling, leaking, ecchymosis, nodules (lipohypertrophy), warmth, or burning.
4. The importance of immediately reporting any pain, burning, sensation changes, or feeling of fluid on skin during all infusion.
5. Storage, handling and disposal of medications, equipment, and supplies
6. Universal precautions
7. Pain assessment
    a. Pain scale:
        i. Pain 1-10 scale.
        ii. Baker-Wong Face Scale
8. Sedation 1-10 scale.
9. Discussion of pain, the risk for pain, the importance of adequate and effective pain management, the pain assessment process and methods for pain management.
10. Diagnosis and evaluation of goals of therapy established in the patient's plan of care.
11. Education is to be individualized based on condition, assessment needs, and patient abilities.
12. When and how to contact the pharmacy, provider and emergency services.

P. Documentation and Assessment should include:

1. Type and location of catheter, date of insertion with initial assessment, if available
2. Catheter site care
3. Name of drug, concentration rate, bolus ability and frequency of patient use of bolus
4. Infusion technique and infusion control device used
5. Storage and disposal of controlled substances
6. Response to pain management: adult patients will be asked to rate pain on a scale of 0-10 (0 being no pain, and 10 being the worst pain imaginable). Pediatric patients will be asked to rate

pain on the Baker-Wong face scale. Pain of infants less than 2 years old or obtunded patients will be ascertained by the caregiver, based on non-verbal cues.

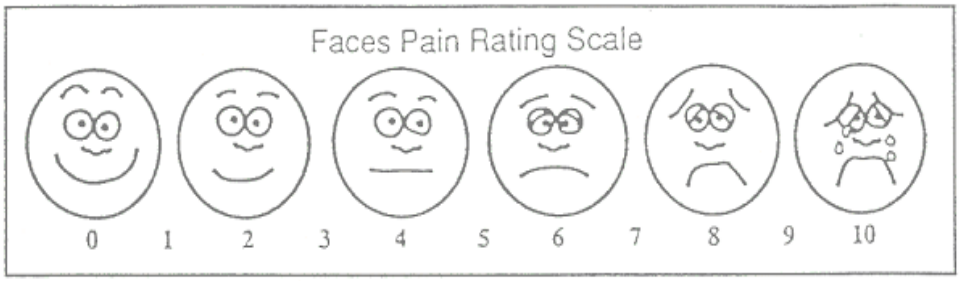
7. Patient assessment should include:
    a. Evaluation and documentation of response(s) to pain intervention(s), including pain location, frequency and duration.
    b. Progress toward pain management goals including functional ability.
    c. Risk factors for adverse events caused by the treatment.
    d. all methods the patient uses to relieve pain.
8. Personal, spiritual, cultural and/or ethnic beliefs may influence the patient or family/caregiver perceptions and expectations of pain and its management.

Appendix A: Pain & Sedation Scales

PAIN SCALE

Increment	Pain Level
1	No Pain
2	Comfortable
3	Comfortable with predictable episodes of pain managed by bolus
4	
5	Comfortable with infrequent bolus
6	
7	Uncomfortable with infrequent boluses
8	
9	In pain; using bolus at maximum; no relief
10	Worst imaginable pain

BAKER-WONG (FACES) SCALE



SEDATION SCALE

Increment	Sedation Level
1	Awake and alert
2	
3	Drowsy
4	
5	Dozing
6	
7	Asleep
8	
9	Asleep but arouses by shaking
10	Somnolent

REFERENCES

Infusion Nurses Society. 8th Edition (2021). Infusion Therapy Standards of Practice. *Journal of Infusion Nursing, Volume 44.*

Accreditation Commission for Health Care (7/21/2022). *ACHC Standards.*

The Joint Commission. (2022). *Joint Commission Resources E-dition.*