• Pain is an unpleasant sensory & emotional experience associated with actual or potential tissue damage or described in terms of such damage

• Our promise to patients ... we will always:
  ◦ Work as a team to evaluate, treat & prevent pain
  ◦ Listen to patients and take reports of pain seriously
  ◦ Try to respond promptly to reports of pain
  ◦ Provide information about pain and its treatment

NOTE: Patients who are unwilling/unable to verbalize pain still can feel it!
All admitted patients are screened for pain

When present, a pain assessment is done
  ◦ Includes intensity, location and nature
  ◦ Use age & ability appropriate scale to measure pain

When intensity is above 5 on the scale
  ◦ Treatment is provided & response reassessed
  ◦ When severe pain persists refine treatment plan or seek specialty guidance
Choosing a Pain Intensity Scale

- Adult
  - Able to discuss pain
    - Verbal
    - Numeric
    - Functional
    - Faces
  - Unable to discuss pain
    - CNPI
      Checklist of Nonverbal Pain Indicators
    - PAINAD
      Pain Assessment in Advanced Dementia
**Pain Assessment Intensity Indicator**

After describing the nature & location of the discomfort, please rate its intensity on *ONE* of the scales.

**Numeric Pain Scale**

- No Pain
- 0
- Mild
- 1
- Moderate
- 2
- Severe
- 3
- Extreme
- 4
- Worst Pain
- 5
- 6
- 7
- 8
- 9
- 10

**Verbal Descriptor Pain Scale**

- No Pain
- Mild
- Moderate
- Severe
- Extreme
- Worst Pain

**Functional Pain Scale**

- No Pain
- Doesn’t interfere with activities
- Tolerable
- Interferes with some active activities
- (4)
- Interferes with active, but not passive activities
- (6)
- Interferes with even passive activities
- Intolerable
- Incapacitated, by pain

Active activities: usual activities or those requiring effort (turning, walking, etc)
Passive activities: talking on phone, watching TV, reading
Faces Pain Scale – Revised (FPS-R)

- In the following instructions, say "hurt" or "pain," whichever is best understood. "These faces show how much something can hurt."

- This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to right-most face] – it shows very much pain. Point to the face that shows how much you hurt [right now]."

- Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Do not use words like 'happy' and 'sad.' This scale is intended to measure how people feel, not how their face looks.
# Checklist of Nonverbal Pain Indicators (CNPI)*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>At Rest</th>
<th>With Movement</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vocal Expressions:</strong> Moans, groans, grunts, cries, sighs, gasps, “ouch”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facial Expression:</strong> Wincing, grimace, furrowed brow, tight lips/jaw</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bracing:</strong> Clutching, holding side rails, bed tray, table, or area of pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Restlessness:</strong> Shifting position, hand movements, unable to keep still</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rubbing:</strong> Touching, holding, rubbing or massaging affected area</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0 = behavior not observed  
1 = behavior observed at rest OR movement  
2 = behavior observed at rest AND movement  

**TOTAL:** (0-10)

---

# Pain Assessment in Advanced Dementia: PAINAD

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score = 0</th>
<th>Score = 1</th>
<th>Score = 2</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breathing:</strong></td>
<td>Normal breathing</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respiration</td>
<td></td>
</tr>
<tr>
<td><strong>Negative vocalizations:</strong></td>
<td>None</td>
<td>Occasional moan/groan. Low level, speech with a negative or disapproving quality</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying.</td>
<td></td>
</tr>
<tr>
<td><strong>Facial Expression</strong></td>
<td>Smiling or inexpressive</td>
<td>Sad, frightened, frown</td>
<td>Facial grinsce</td>
<td></td>
</tr>
<tr>
<td><strong>Consolability:</strong></td>
<td>No need to console</td>
<td>Distracted by voice or touch.</td>
<td>Unable to console, distract or reassure.</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**

---

*Scoring modified to standardize to the MGH policy of ranking pain on a 0-10 scale*
<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Proper Use</th>
<th>Common Errors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numeric Pain Scale</td>
<td>Ask “on a scale of 0 - 10; if 0=no pain or discomfort and 10= worst pain imaginable; how much are you experiencing now?”</td>
<td>Ask “on a scale of 1 to 10…” and fail to define anchors, fail to define “0” as the lower anchor</td>
</tr>
<tr>
<td>Verbal Descriptor Scale</td>
<td>After ruling out “none” and “worst possible pain,” ask “is your pain mild, moderate severe, or extreme in intensity?” Document associated numbers (e.g. 2, 4, 6, 8)</td>
<td>Failure to define &amp; rule out anchors. Trying to get the patient to tell you a number after rating it with words; or resolve related discrepancies</td>
</tr>
<tr>
<td>Functional Pain Scale</td>
<td>Determine if there is pain (&gt;0); its tolerability (&lt;5); and the extent it interferes with activities that require different levels of exertion. Discuss clinical goals /observations</td>
<td>Trying to get the patient to tell you a number; or resolve discrepancies.</td>
</tr>
<tr>
<td>Faces Pain Scale</td>
<td>Ask patient to point to the face that shows level of hurt right now.</td>
<td>Look at patient to evaluate facial expression.</td>
</tr>
</tbody>
</table>
Step 1
Make sure the date and time highlighted is for the correct analgesic administration being reassessed.
Step 2
Make sure to select the assessment tool used.

Step 3
Click on the number representing pain intensity score.

Step 4
Document the presence or absence of adverse effects.
• Establish goals with your patient together!
  ◦ Post the established goal on the in-room white board

• Always try to eliminate/control cause of pain

• Analgesics provide partial, temporary relief
  ◦ 50% less pain considered “good” for acute or cancer pain
  ◦ 30% less pain considered “good” for chronic pain

• Balance desire for pain reduction with:
  ◦ Improved functioning (self care, participation in therapy)
  ◦ Avoidance of drug related side effects
  ◦ Developing nondrug skills to better cope with pain
  ◦ Promoting dignity (especially @ end of life)
  ◦ Goals should be SMART: Specific, Measurable, Attainable, Relevant & Time-bound
- No exposure to opioids in past 90 days
- May be more sensitive to opioids than others
- Treatment considerations
  - Choose drugs with few side effects
  - Avoid substances that have euphoric effects
- “Start low and go slow” principle
  - With range orders start with lowest dose
  - Adjust therapy +/- 25% based on response
- Monitor responses closely for high risk patients
  - History of respiratory, renal or hepatic disorders
  - CNS depression
  - History of substance abuse or addiction disorder
Opioid Tolerant Patients

- Prescribed opioids pre-admission
- Daily exposure for > 1 week to 60 mg oral Morphine /day or equivalent
  - Examples:
    - 40 mg Oxycodone / day
    - 15 mg oral Dilaudid / day
- Non-medical users (daily use of opioids not prescribed)
  - Self-treatment
  - Substance use/addiction disorder
- Treatment considerations
  - Calculate 24 hour opioid use in Oral Morphine Equivalents and start therapy +/- 25% of daily dose to prevent overmedicating or triggering withdrawal
  - Caution still needed when changing from an immediate acting medication to an extended release form
<table>
<thead>
<tr>
<th>Drug</th>
<th>Oral</th>
<th>Parenteral</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30mg</td>
<td>10mg</td>
<td>Parenteral Morphine 3 times more potent than oral morphine</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20mg</td>
<td>NA</td>
<td>Oral Oxycodone is half the potency of parenteral morphine</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>20mg</td>
<td>NA</td>
<td>Oral Hydrocodone is 1.5 times more potent than oral morphine</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5mg</td>
<td>1.5mg</td>
<td>Parenteral Hydromorphone is 7 times more potent than parenteral morphine &amp; 20 times more potent than oral morphine</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>NA</td>
<td>100mcg/hr</td>
<td>Parenteral Fentanyl is 100 times more potent than IV morphine</td>
</tr>
</tbody>
</table>
Your patient used 18mg IV Dilaudid in the past 24hrs. Calculate a transition to oral morphine using formula below:

- Calculate based on cross-multiplication formula

\[
\frac{1.5\text{mg IV Dilaudid}}{30\text{mg Oral Morphine}} = \frac{18\text{mg IV Dilaudid/ day}}{N \ (24\text{hrs po Morphine/day})}
\]
Practice Example for Morphine Equivalency

1.5mg IV Dilaudid = 18mg IV Dilaudid/day
30mg Oral Morphine = N (24hrs po Morphine/day)

- $30 \times 18 = 1.5 \times N = \frac{540}{1.5} = N$
- $N = 360$mg po Morphine per day

- With a 25-50% reduction in starting range, start conversion at 180mg-270mg po morphine/day
**Sample order:**
- 1-2 tablets Oxycodone every 4 hours prn pain when tolerating oral medicines
- 2-4mg IV Morphine Q4 hours prn pain

**Medications given:**
- At 8:00am 1 tab Oxycodone given for pain
- At 9:00am pain unchanged.
- Patient is alert, VSS, without side effects

**Treatment options:**
- Can repeat Oxycodone dose (1 tab) at 9:00am with no additional analgesic until 1:00pm (“reset the clock”) - OR - wait and at noon give 2 tabs - OR – IV morphine

“Rolling Clock” Concept
• If no contradictions, choose Morphine over Dilaudid for severe pain.

Why?

• Dilaudid has more euphoric effects

• Dilaudid users have a higher risk of developing opioid tolerance

• Dilaudid has more adverse drug reactions
PAIN

• Goal- add patient specific goal
  “Patient will ambulate length of hallway with tolerable <5 right hip pain. Goal of <5 established with patient.”

• Interventions- incorporate patient specific interventions including drug and non-drug relief methods
  “Administer pain medications 30 minutes before PT session. Offer repositioning and heat packs post PT session”.

• Current Assessment- your shift assessment
  “Patient able to ambulate length of hallway with walker and PT after receiving Oxycodone; reports 4/10 pain. Reported comfort with heat packs and positioning.”
The Severe Pain Report is a report generated on a daily basis from data collected in eMAR.

It is used to identify patients with pain problems.

YOUR documentation of how a patient is rating their pain is compiled over a 24 hour period.

All patients who rate their pain ≥ 5 out of 10 will show up on this report.

This report can be accessed by EVERYONE.
Accessing the Severe Pain Report

(Step 1)

Review and Transcribe eMAR Screen eMAR Views

Report Refresh

Worksheet (short)
Worksheet (long)
Transfer/Discharge
Administrations Summary
Administrations By Date
Med Overview
Change Med Overview
Transfer/Discharge
Medication Not Administered
Unknown Administrations
Missing Administrations
On Paper/OLS Admins
Alert Report
Amend
Purge Previous Session
Respiratory Medications
Schedule Changes
Partial Dose
Reconcile Check
Vaccination Administrations
Vaccines Documented as Not Given in eMAR
Vaccine Recall Report
Independent Double Check Report

(Step 2)

Med Overview
AHFS Class

Change to FENTANYL CITRATE
3.3 MC G IV BOLUS Q1H PRN:
Pain Routine FROM FENTANYL

(Step 3)

Go into eMAR (any patient), hover over reports, drop cursor down to select other reports, then draw cursor down to select Severe Pain Report.
Select the unit, date, and how you want the data displayed.
The Pain Worksheet is a tool designed to help you collect information and formulate an effective pain regimen for your patient.

Organizes facts regarding pain treatment plan
- Background information, home regimens, response to hospital treatment, and more options/resources

When do we use this?
- Patient identified on the Severe Pain Report
- Patient with hard to control pain
- Patient with over sedation or other adverse drug reactions
- Patient with poor response to current treatment plan
- Upon your clinical judgment
Pain Assessment Worksheet

Date: __________ Admit Date: __________ MRN: __________ Primary Diagnosis: __________

Pain delaying discharge? __Yes__ __No__ Is the source of the pain known? __Yes__ __No__

Pain Type(s): __Acute__ __Chronic__ Pain interferes with ADLs or Rehab? __Yes__ __No__

Pain Location: __________ Pain Description: __________

Pain Scale Used: __________ Is the scale a good choice for the patient? __Yes__ __No__

Patient centered comfort goal: __________

Treatment of Pain at Home

Was pain being treated at home? __Yes__ __No__

If no, skip to the back page

Check all that apply:

- Opioids (e.g., Morphine, Dilaudid, Hydromorphone, hydrocodone, oxycodone, methadone)
- Non-opioids (e.g., Tylenol or NSAIDs)
- Adjunct medication (e.g., Gabapentin, Pregabalin, Dexamphetamine, Nortriptyline, Lisuride)
- Herbal or nutritional supplements
- Physical approaches (e.g., exercise, heat/cold, OT/PT, massage, TENS, positioning)
- Cognitive approaches (e.g., education, distraction, relaxation techniques, reframing)
- Self-management (e.g., home remedies, alcohol, drug or addictive use, prayer, aging)

Is this patient on opioids at home? __Yes__ __No__ If yes, consider Pharmacy and/or Pain Service consult because this may indicate the patient is opioid tolerant and may require specialized pain management.

Is the patient currently ordered for their home dose of pain medications? __Yes__ __No__

If no, collaborate with MDs to determine why. If appropriate, resume home dose of pain medications.

Current Hospital Pain Treatment Plan

**Scheduled pain medications**: (opioid and non-opioid, including adjuvants)

<table>
<thead>
<tr>
<th>Med</th>
<th>Dose</th>
<th>Schedule</th>
<th>Amount per day ordered</th>
<th>Amount given past 24hours</th>
</tr>
</thead>
</table>

**PRN pain medications**: (opioid and non-opioid)

<table>
<thead>
<tr>
<th>Med</th>
<th>Dose</th>
<th>Schedule</th>
<th>Amount per day ordered</th>
<th>Amount given past 24hours</th>
</tr>
</thead>
</table>

For each medication, compare the total amount per day ordered to the total amount given in the past 24 hours. Are they the same? __Yes__ __No__

If yes, inform MD that patient continues with uncontrolled pain while receiving full dosing potential. If no, consider administering medications to full dosing potential (if clinically reasonable).

Other Considerations

- Initiate pain discussion with multidisciplinary team, utilizing worksheet to articulate patient status and your recommendations.
- Collaborate with MD to consider dose adjustments by 25-50% or addition of another agent for multimodal therapy (more than one drug class).
- Consult Acute Pain, Chronic Pain or Palliative Care Service. If already consulted, make sure that all recommendations are being followed. Call appropriate service with any questions.
- Consider adjustments to non-drug treatment plan (e.g., cold therapy, warm therapy, repositioning, meditation...).
- Other Resources: Pain CNS, Psychiatric CNS, Unit-based CNS, Psychiatry, Pet Therapy, Chaplaincy, and EED Portal Page.
Case Study: Mr. G

- 42 year old unemployed male
- H/o cholecystitis and moderate alcohol use
- Admitted for acute on chronic pancreatitis
- Complains of 10/10 abdominal pain
  - Controlled with Dilaudid on previous admissions
- Very dissatisfied IV Dilaudid not prescribed this admission
- Identified on the Severe Pain Report
- Nursing concerned that patient has had difficult to control pain since admission
Pain Worksheet

- **Date:** 3/3/14  
  **Admit Date:** 3/1/14  
  **MRN:** xxxxxx  
  **Primary Diagnosis:** Pancreatitis

- Pain delaying discharge? __x__Yes___No  
  Is the source of the pain known? _x__Yes ___ No

- Pain Type(s): _x__Acute _x__Chronic  
  Pain interferes with ADLs or Rehab? __x__Yes ___No

- Pain Location: **abdominal**  
  Pain Description: **sharp, diffuse**

- Pain Scale Used: **numeric**  
  Is the scale a good choice for the patient? __x__Yes ___No

- Patient centered comfort goal: **Reduction in pain to 7/10 both at rest and with activity**  
  i.e. sitting in the chair.
Treatment of Pain at Home

Was pain being treated at home?  _x__Yes___No  
*If no, skip to the back page*

Check all that apply:

- Opioids (e.g., Morphine, Dilaudid, **Oxycodone**, Oxycontin, Vicodin, Fentanyl, Hydrocodone)
  - [x] Opioids
- Non-opioids (e.g., Tylenol or NSAIDs)
  - [ ] Non-opioids
- Adjuvant medication (e.g., **Gabapentin**, Pregabalin, Duloxetine, Nortriptyline, Lidoderm)
  - [x] Adjuvant medication
- Herbal or nutritional supplements
  - [ ] Herbal or nutritional supplements
- Physical approaches (e.g. exercise, heat/cold, OT/PT; massage, TENS, positioning)
  - [ ] Physical approaches
- Cognitive approaches (e.g. education, distraction, relaxation techniques, reframing)
  - [ ] Cognitive approaches
- Self-management (e.g. home remedies, **alcohol**, drug or sedative use, **prayer**, coping)
  - [x] Self-management

Is this patient on opioids at home?  _x__Yes___No  
*If yes, consider Pharmacy and/or Pain Service consult because this may indicate the patient is opioid tolerant and may require specialized pain management.  *(15mg Oxycodone TID at home x 5 months)*

Is the patient currently ordered for their home dose of pain medications?  ___Yes ___x__No  
*If no, collaborate with MDs to determine why. If appropriate, resume home dose of pain medications and adjuvant therapies.*
**Current Hospital Pain Treatment Plan**

- **Scheduled pain medications**: *(opioid and non-opioid)*
  - **Med** | **Dose** | **Schedule** | **Amount per day ordered** | **Amount given (24 hours)**  
  - Neurontin | 100mg | BID | 200mg possible | received 200mg

- **PRN pain medications**: *(opioid and non-opioid)*
  - **Med** | **Dose** | **Schedule** | **Amount per day ordered** | **Amount given (24 hours)**  
  - Oxycodone | 5mg | q4 | 30mg possible | received 30mg
  - Ibuprofen | 400mg | q4 | 2400mg possible | received 800mg
For each medication, compare the total amount per day ordered to the total amount given in the past 24 hours.

Are they the same? ___Yes ___x__No

- Oxycodone was given at max dosing potential but patient had an additional 1600mg of Ibuprofen he could have received.
- Given opioid use at home it is likely that he will require higher doses of pain medication to achieve pain relief.
- Patient requires 45mg Oxycodone per day to achieve pain relief but only ordered for total of 30mg for day in the hospital.

If yes, inform MD that patient continues with uncontrolled pain while receiving full dosing potential.

If no, consider administering medications to full dosing potential (if clinically reasonable).
Other Considerations

- Initiate pain discussion with multidisciplinary team, utilizing worksheet to articulate patient status and your recommendations.

- Collaborate with MD to consider dose adjustments by 25-50% or addition of another agent for multimodal therapy (more than one drug class).

- Consult Acute Pain, Chronic Pain or Palliative Care Service. If already consulted, make sure that all recommendations are being followed. Call appropriate service with any questions.

- Consider adjustments to non-drug treatment plan (e.g., cold therapy, warm therapy, repositioning, meditation ...).

- Other Resources: Pain CNS, Unit-based CNS, Psychiatry, Pet Therapy, Chaplaincy, and EED Portal Page.
• Always confirm a patient’s home regimen for pain medication

• When patients are opioid tolerant they may require higher doses of pain medication to achieve relief

• Be sure to compare a patient’s home regimen against the current treatment plan

• Confirm that the patient is receiving all of the medications they are ordered for

• If pain continues to be poorly controlled access the resources readily available at MGH
• Chronic Pain Service: pager 17246 (1-PAIN)
• Acute Pain Service: pager 27246 (2-PAIN)
• Palliative Care Service
• Unit-based Pain Relief Champions
• Unit-based Collaborative Governance Pain Champion
• Paul Arnstein, Clinical Nurse Specialist of Pain Relief: pager 13386
• Unit-based Clinical Nurse Specialist
• C.A.R.E. Relaxation Channel 45
• EED page
  ◦ Partners Applications->PCS Clinical Resources->Excellence Every Day Portal->Pain

Accessing Resources