GENERAL STATEMENT OF PURPOSE

To establish a standard for routine assessment, reassessment and documentation of pain as appropriate to the patient’s condition and treatment regimen.

POLICY

Pain is assessed in all patients. Individuals are assessed based upon their clinical presentation, services sought and in accordance with the care, treatment, and services provided. The hospital uses methods to assess pain that are consistent with the patient’s age, condition, and ability to understand.

SCOPE

This policy applies to all members of the North Shore – LIJ Health System work force including, but not limited to employees, medical staff, volunteers, students, physician office staff and other persons performing work for or at North Shore – LIJ Health System.

PROCEDURE/GUIDELINES

I DEFINITIONS

_Health Care Provider_ – includes but is not limited to the following: Registered Nurse (RN), Clinical Nurse Specialist, Physician, Registered Dietician, Certified Nurse Midwife, Nurse Practitioner, Physical Therapist, Occupational Therapist, Respiratory Therapist, Physician’s Assistant.

_Pain Measurement Scales_ (see attachment) – the attached pain measurement scales are approved for use. Selection of a particular scale is based on the patient’s age and / or abilities.

Inpatient / Ambulatory

Neonate: _Neonatal Infant Pain Scale_ (NIPS) from birth to 45 weeks corrected gestational age- then use FLACC.

Pediatrics less than 3 years of age /

Patients unable to communicate: _Face, Legs, Activity, Cry, Consolability_ (FLACC)

Pediatrics 3 years of age and over: _Wong-Baker Faces Pain Rating Scale_

Pediatrics over 6 years of age who understand concepts of rank & order: _Numeric Pain Rating Scale_

Adult: _Numeric Pain Rating Scale_. Consider options of FLACC or Wong-Baker for adults with difficulty expressing numeric values for pain assessment

Geriatric: _Numeric Pain Rating Scale, Wong-Baker Faces Pain Rating Scale, Pain Assessment in Advanced Dementia_ (PAINAD)
II PROCESS

IMPLEMENTATION:

I. Screening

On encounter with the Health System, all patients will be screened by a Health Care Provider for the presence or absence of pain, including pain experienced in the past three months. If the patient’s response is indicative of pain, then a detailed pain assessment is completed.

II. Detailed Assessment

1. All patients who have pain will be assessed upon encounter with the Health System. Ongoing assessment will occur at a minimum of once in each 12 hour period. When a patient’s initial assessment or ongoing assessments are indicative of pain, ongoing assessment should occur at a minimum of every 4 hours. The acronym PQRST provides a guide when describing pain.

Consider asking the following:

**P = Precipitating / Palliative / Provocative factors**
- What were you doing when the pain began?
- Does anything make it better, such a medication or a certain position?
- Does anything make it worse, such a movement or breathing?

**Q = Quality / Quantity**
- **Superficial somatic (body) pain** is sharp, pricking or burning
- **Deep somatic pain** is dull or aching
- **Visceral (internal organ) pain** is dull, aching or cramping
- **Neuropathic (nervous system) pain** is burning, shock-like, lancing, jabbing, squeezing or aching
  - What does it feel like?
  - How often are you experiencing it?
  - To what degree is the pain affecting your ability to perform your usual daily activities?

**R = Region / Radiation / Related Symptoms**
- **Localized pain** confined to site of origin, such as cutaneous (skin) pain
- **Referred pain** is referred to distant structure, such as shoulder pain with acute cholecystitis, or jaw pain associated with angina
- **Projected (transmitted) pain** is transmitted along a nerve, such as herpes zoster or trigeminal neuralgia
- **Dermatomal pattern** as with peripheral neuropathic pain
- **Nondermatomal** as with central neuropathic pain, fibromyalgia
- **No recognizable pattern** as with complex regional pain syndrome
- **Visceral pain related symptoms**: sickening feeling, nausea, vomiting and autonomic symptoms
- **Neuropathic pain related symptoms**: hyperalgesia (extreme sensitivity to painful stimuli) and allodynia (condition in which ordinarily non-painful stimuli evoke pain)
- **Complex regional pain syndrome related symptoms**: hyperalgesia (extreme sensitivity), hyperesthesia (abnormal acuteness of sensitivity to touch, pain or sensory stimuli), allodynia (non-painful stimuli evoke pain), autonomic changes and skin, hair and nail changes
Can you point to where it hurts?
Does the pain occur or spread anywhere else?
Do you have any other symptoms? (i.e., nausea, dizziness, shortness of breath)

S = Severity
- Use appropriate pain scale
- See pain scales below

T = Timing
- Brief flash: quick pain as with needle stick
- Rhythmic pulsation: pulsating pain as with migraine or tooth ache
- Long-duration rhythmic: as with intestinal colic
- Plateau pain: pain that rises and then plateaus, such as angina
- Paroxysmal: such as neuropathic pain
- Continuous fluctuating pain: as with musculoskeletal pain
- When did the pain begin?
  - How long did it last?
  - How often does it occur?
  - Do you have times when you are pain free?

2. If the patient, using one of the attached pain assessment scales, reports pain that is unrelieved by prescribed treatment, then the physician or designee is notified by the registered nurse.

3. In ambulatory settings the patient may need to be referred back to their primary care or other specialty-focused providers for pain management.

4. Persistent (chronic pain) and/or past or present history of substance abuse: Treating medically ill patients who are experiencing chronic pain with past or present substance-abuse problems is complex and challenging. Clinicians should note the following:
   a) Substance abuse can magnify chronic pain due to alterations in pain perceptions
   b) Patients with substance abuse problems may be identified in primary care or ambulatory settings
   c) Consider functional / behavioral status, including ability to perform ADL, work and or normal social interaction.

5. Achieving adequate pain management in the elderly can be complicated by the presence of co morbid conditions, particularly the high prevalence of dementia, sensory impairment, an increased risk of adverse drug reactions and incidence of polypharmacy (see Geriatric Pain Guidelines).

III. Plan of Care

The assessment of pain does not stop upon completion of the screening / admission process. All patients who have pain will have their pain managed based on an individualized plan of care. This plan will be an interdisciplinary approach and will include:

1. Input from the patient and / or significant other.
2. The patient’s pain intensity goal.
3. The pharmacologic / non-pharmacologic interventions appropriate to the patient’s condition and age, such as positioning, physical therapy, cold / heat applications, behavioral therapies, diversional activities, relaxation and imagery techniques, etc.
The Plan of Care should be revised as indicated by the patient’s condition and response to treatment.

IV. Reassessment

At the appropriate interval, the Registered Nurse and / or appropriate Health Care Provider, will reassess the patient’s response to interventions based on the patient’s condition and treatment plan.

1. Assess pain relief from pharmacological and nonpharmacological interventions; monitor the efficacy of the interventions.
   a) PO analgesia: one half to one hour
   b) Subcutaneous and Intramuscular routes (IM route not recommended in the older adult): one half hour.
   c) Intravenous analgesia: fifteen minutes
   d) Patient - controlled analgesia (PCA), continuous drip and / or epidural narcotic infusions: as ordered by prescriber or as required by policy.
   e) PCA or epidural analgesia: fifteen minutes to one half-hour if changes are made in rate.
   f) All non-pharmacological interventions: one half-hour to one hour afterward.

2. If pain management is not adequate, revise the plan in collaboration with the patient / family member, physician and nursing staff.

V. Documentation

1. Assessments, intervention and reassessments will be documented in the appropriate section(s) of the medical record.

VI. Patient / Family / Significant Other Education:

1. Explain to the patient and family that pain can be managed and/or relieved, the importance of reporting pain and the benefits of pain control.

2. Explain to the patient and family the importance of preventing rather than chasing pain in effective pain management.

3. Describe to the patient/family atypical manifestations of pain such as:
   a) Changes in function and gait
   b) Withdrawn or agitated behavior
   c) Increased confusion

4. Teach family members to use a pain scale at home. Once the appropriate tool has been determined, continue to use that particular scale.

5. Allay common fears/misconceptions regarding opioid use, such as addiction and respiratory depression.

6. Explain common side effects of analgesics (constipation, sedation, and nausea).
7. Teach nonpharmacological interventions and inform the patient/family that these interventions complement the treatment plan.

8. Patient and/or significant other will also be educated regarding:
   a. Their rights to have their pain recognized and managed as part of treatment.
   b. Their role and participation in the overall treatment plan and management of their pain, including identifying cultural, spiritual, or personal beliefs, which should be taken into consideration in formulating an individualized pain management plan.
   c. Other education as identified by assessment and reassessment process.

VII. **Discharge Planning**

1. The discharge process provides for continuing care based on the patient's assessed needs at discharge.
2. The Pain Management Plan will be communicated to the next care provider. (e.g., patient, family, skilled nursing facility, home care, etc.). This plan will identify the patient’s pain level, the patient’s goal of treatment, the scale utilized, location of pain, pharmacological interventions including last dose given and non-pharmacological strategies.

Policy Review / Revision / History

<table>
<thead>
<tr>
<th>Standardized by North Shore Long Island Jewish Health System Policy/Procedure Committee: 12/14/01</th>
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<tbody>
<tr>
<td>Reviewed / Revised by: North Shore LIJ Health System Nursing Policy &amp; Procedure Committee: 06/16/05, 8/3/06, 10/10</td>
</tr>
<tr>
<td>Approved by North Shore Long Island Jewish Health System Nurse Executive Council: 9/15/06 : Effective 11/15/06. 11/30/10</td>
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</table>

III REFERENCES TO REGULATIONS AND OR OTHER RELATED POLICIES

2010 Hospital Accreditation Standards JC PC.01.02.07

IV CLINICAL REFERENCES


North Shore - LIJ Health System Geriatric Guidelines: *Pain Management*.


**APPLICABLE SITES:**

Cohen Children’s Medical Center  
Forest Hills Hospital  
Franklin Hospital  
Glen Cove Hospital  
Huntington Hospital  
Lenox Hill Hospital  
Long Island Jewish Medical Center  
North Shore University Hospital  
Orzac CECR  
Plainview Hospital  
Southside Hospital  
Staten Island University Hospital  
Stern CECR  
Syosset Hospital  
The Zucker-Hillside Hospital
# NEONATAL INFANT PAIN SCALE (NIPS)

Infants less than or equal to 1 month of age.

A score greater than 3 indicates pain.

## FACIAL EXPRESSIONS

0 – Relaxed Muscles: Restful face, neutral expression  
1 – Grimace: Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression – nose, mouth, and brow)

## CRY

0 – No cry: Quiet, not crying  
1 – Whimper: Mild moaning, intermittent  
2 – Vigorous cry: Loud scream, rising, shrill, continuous (Note: silent cry may be scored if baby is intubated as evidenced by mouth and facial movements)

## BREATHING PATTERNS

0 – Relaxed: Usual pattern for this infant  
1 – Change in Breathing: In drawing, irregular, faster than usual; gagging; breath holding

## ARMS

0 – Relaxed/Restrained: No muscular rigidity; occasional random movements of the arms  
1 – Flexed/extended: Tense, straight arms; rigid and/or rapid extension, flexion

## LEGS

0 – Relaxed/Restrained: No muscular rigidity; occasional random leg movement  
1 – Flexed/extended: Tense, straight legs; rigid and/or rapid extension, flexion

## STATE OF AROUSAL

0 – Sleeping/Awake: Quiet, peaceful sleeping or alert random leg movement  
1 – Fussy: Alert, restless, and thrashing

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# FLACC SCALE (FACE, LEGS, ACTIVITY, CRY, CONSOLABILITY)

Patients less than 3 years of age or patients unable to communicate.

<table>
<thead>
<tr>
<th>SCALE</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FACE</strong></td>
<td>No particular expression or smile. Facial muscles relaxed</td>
<td>Facial muscles tense grimacing, frowning, withdrawn</td>
<td>Frequent to constant frown, clenched jaw, <strong>quivering chin</strong></td>
</tr>
<tr>
<td><strong>LEGS</strong></td>
<td><strong>Normal position</strong>, quiet, relaxed</td>
<td>Occasional restlessness, shifting positions</td>
<td>Frequent to restlessness, <strong>kicking, legs drawn up</strong></td>
</tr>
<tr>
<td><strong>ACTIVITY</strong></td>
<td>Normal muscle tone, lying quietly, relaxed</td>
<td><strong>Squirming</strong>, tense, flexion of fingers and toes</td>
<td>Rigid tone, <strong>arched, jerking</strong></td>
</tr>
<tr>
<td><strong>CRY</strong></td>
<td><strong>No cry (awake or asleep)</strong></td>
<td>Moans or Whimpers; Occasional Complaint</td>
<td>Frequent or continuous grunts moans, whimpers, or cries</td>
</tr>
<tr>
<td><strong>CONSOLABILITY</strong></td>
<td>Content; Relaxed</td>
<td>Reassured by touching, talking to, hugging, rocking, Distractible</td>
<td>Difficult to comfort/console by touching, talking to, hugging, or rocking</td>
</tr>
</tbody>
</table>

The areas in bold print are pediatric specific for the ages 1 month to 7 years.
NUMERIC

Pain Rating Scale

Patient over the age of 6 who understands the concept of rank and order.

0-10 Visual Analog Scale

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO PAIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WORST POSSIBLE PAIN</td>
</tr>
</tbody>
</table>

WONG-BAKER FACES

Pain Rating Scale

Patients 3 years of age and older

Using the pain rating scale is helpful for patients to communicate how much pain they are feeling.

Instructions:

Explain to the patient that each face is for a person who feels happy because he/she has no pain (hurt) or sad because he/she has some pain, or a lot of pain.

Face 0 is very happy because he/she doesn’t hurt at all.
Face 2 hurts just a little.
Face 4 hurts even more.
Face 6 hurts even more
Face 8 hurts a whole lot more.
Face 10 hurts as much as you can imagine, although you do not have to be crying to be feeling this bad.

Ask the patient to choose the face that best describes how he/she is feeling.
The **PAINAD** (Pain Assessment in Advanced Dementia) is a valid and reliable instrument for measurement of pain in cognitively impaired patients.

### PAINAD SCALE

<table>
<thead>
<tr>
<th>BREATHING</th>
<th>NEGATIVE VOCALIZATION</th>
<th>FACIAL EXPRESSION</th>
<th>BODY LANGUAGE</th>
<th>CONSOLABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Normal</td>
<td>None</td>
<td>Smiling, or inexpressive</td>
<td>Relaxed</td>
<td>No need to console</td>
</tr>
<tr>
<td>1 Occasional labored breathing. Short period of hyperventilation</td>
<td>Occasional moan or groan. Negative quality speech.</td>
<td>Sad, frightened, frown</td>
<td>Tense, Distressed pacing. Fidgeting</td>
<td>Distracted or reassured by voice or touch.</td>
</tr>
</tbody>
</table>

**Add ratings of each of the 5 categories and obtain the TOTAL SCORE:** *(Warden, V., Hurley, A., & Volicer, L. (2003)).*

**EFFECTIVE:** NOVEMBER 2006

**SIGNATURES:** To Include Name / Title / Date