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Purpose

The purpose of this policy is to establish a standardized process for the appropriate assessment and management of pain in all ICU patients.


Description

Introduction:

Sedatives and analgesics are the most commonly administered medications in both surgical and medical ICU's accounting for 10 - 15% of the total drug costs. Despite JCAHO mandates and available guidelines, inadequate or excessive sedation and analgesia is still common in intensive care units.

- Failure to meet goals of proper sedation and analgesia have deleterious sequels that are associated with an increase in adverse events, poor outcomes, longer ICU stays and economic effects.
- Use of tools such as the Ramsay sedation scale as well as the Visual Analog Scale (VAS) and the FACES scale for pain have made titration of drugs more precise and cost effective
- In an attempt to improve sedation and analgesia in our ICU patients, thereby improving patient outcome and costs, the following guidelines have been created.
- These guidelines are based on recommendations developed by the Society of Critical Care Medicine (January 2002) combined with data on the Pharmacodynamics and pharmacokinetics of the drugs in the critically ill
- the Ramsay sedation scale or the Richmond Agitation Sedation Scale (RASS) and the VAS and FACES scale for pain assessment will be the standard used.

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1.0 Policy

1) Pain Assessment and Management in Patient Care Areas


- 1.1 Patients have a right to assessment of pain and to appropriate intervention when pain is present or anticipated.
- 1.2 This policy applies to all ventilated ICU treated patients in R.M.H
- 1.3 All healthcare providers are responsible and accountable for ensuring effective pain management.

2.0 Procedure:

Pain Assessment:

- 1.0 Pain severity and pain relief shall be assessed and reassessed at regular intervals, and this information shall be used in deciding the appropriate intervention, which may include pharmacological and non-pharmacological techniques.
- 1.2 Only approved pain assessment scales shall be utilized (FLOW CHART 1)
- 1.3 Pain assessment scales shall be selected based upon the patient's developmental, emotional and cognitive status.
- 1.4 The same pain scale shall be used every time the patient is assessed for pain. The pain scale shall only be changed if there is a change in the patient's

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cognitive status.

1.5 The patient’s or guardian’s report is the most reliable indicator of pain and effectiveness of interventions.

1.6 All patients shall have a goal for pain relief (“comfort goal”) established upon admission by the physician in charge of the patient.

1.7 The comfort goal shall be determined based upon function and quality of life.

1.8 The physician and/or nurse shall collaborate with the patient or guardian to determine the rating on the pain scale at which the patient would be able to function or have an acceptable quality of life.

1.9 Healthcare providers in all disciplines and settings are expected to be knowledgeable and skilled in pain assessment and management as applicable to their practice.

3.0 Pain Management


3.1 A pain management treatment plan shall be developed by the physician and nurses based on appropriate assessment, pain severity, and multi-disciplinary evaluation and input.

3.2 Selection of the intervention(s) shall be based on the nature, severity, and expected duration of pain, as well as the patient history, developmental age and goals of treatment.

3.3 Anticipated pain related to procedures (e.g.; dressing changes, circumcision, lumbar puncture) shall be included in the pain management plan.

3.4 Consultation with or referral to pain experts (Pain Service, Palliative Care Service) shall be pursued when appropriate.

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3.5 The pain management interventions, whether pharmacological or non-pharmacological, shall continue until the effective outcome of pain reduction is achieved to the satisfaction of the patient and health care provider.

3.6 The effectiveness of the pain management treatment shall be evaluated on an ongoing basis and modified based upon the assessment findings.

- Persistent unrelieved/uncontrolled pain shall be communicated by the nurse/healthcare provider to the physician.
- Pain score consistently above the patient’s acceptable level, “comfort goal”, or less than or equal to 4 out of 10 on 2 successive occasions for adults and pediatrics and less than or equal to 7 out of 21 for neonates shall trigger a review of the treatment regimen and a modification of the management plan.
- Pain ratings which continue to be at an unacceptable level post modification of the treatment regimen shall result in a referral/consultation with the Pain Service.

4.0 Pharmacologic Interventions

4.1 Pharmacological Treatment


Non-opioids

- Acetaminophen
- NSAIDs

Opioids Agonists

- Combination products –opioid agonists and acetaminophen or NSAID
- Tramadol

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Adjuvant Medications

- Benzodiazepines
- Tricyclic Antidepressants
- Anticonvulsants
- Topical/Local/Regional Anesthetics
- Oral sucrose


5.0 Pharmacological Management and the Mechanism of Pain (i.e. Neuropathic vs. Nociceptive) Shall be Guided by Pain Severity

- Mild pain (1-3) may be treated with non-opioids
- Moderate pain (4-6) may be treated with nonopioid and/or opioid
- Severe pain (7-10) may be treated with nonopioid and/or opioid. The opioid selection and route of administration may vary from those selected for treatment of mild to moderate pain.
- Oral and intravenous administrations are the preferred routes. Rectal and transdermal should also be considered before intramuscular injections.
- Medications for persistent pain should be administered around the clock.
- PRN dosing is appropriate for intermittent pain, including breakthrough or activity related pain, pain that is escalating or decreasing rapidly.
- Placebos shall not be used as part of any pain management plan.
- Meperidine should not be considered as a first choice opioid in the treatment of pain especially when needed for 48 hours or more.
- Anticipate common side effects of analgesics by early interventions, i.e. laxatives to prevent constipation.

6.0 Non-Pharmacologic Interventions

6.1 Non-pharmacologic measures should be selected based upon patient preference, developmental age effectiveness of prior use, pain and anxiety level of patient and guardian, and the ability and willingness of the patient and guardian to

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follow instructions and degree of pain relief obtained.

6.2 Non-pharmacologic interventions incorporate multiple modalities and techniques.

- Repositioning
- Heat or cold
- Non-nutritional sucking (pacifier)
- Active and/or passive physical/occupational therapy
- Distraction
- Massage

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Flow chart 1
Visual Analog Scale (VAS)



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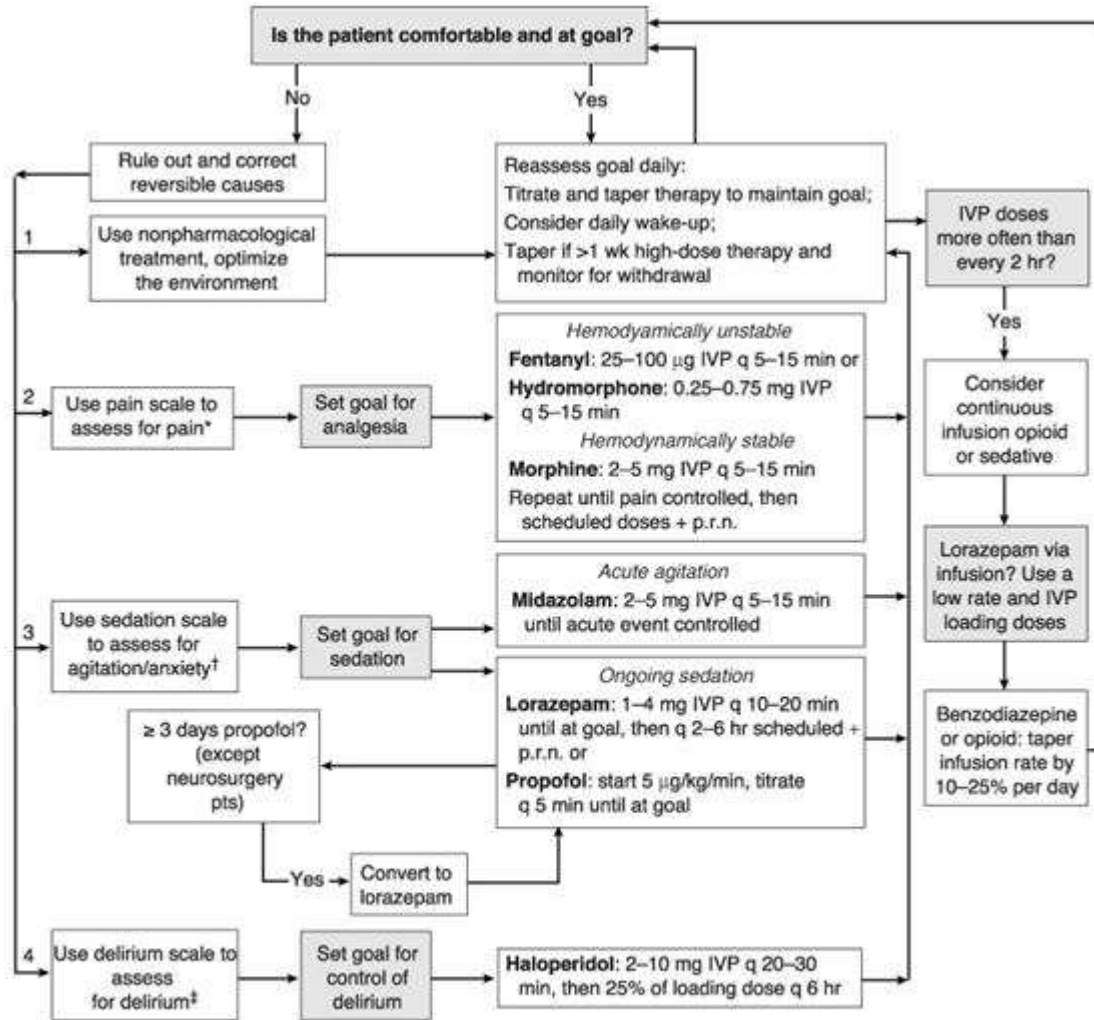


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*Numeric rating scale or other pain scale.
 †Ricker Sedation-agitation scale or other sedation scale.
 ‡Confusion Assessment Method for the ICU.

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Ramsay Scale

Sedation level	Description
1	Anxious and agitated
2	Cooperative, tranquil, oriented
3	Responds only to verbal commands
4	Asleep with brisk response to light stimulation
5	Asleep without response to light stimulation
6	Non responsive

Richmond Agitation Sedation Scale (RASS)

Target RASS	RASS Description
+4	Combative, violent, danger to staff
+3	Pulls or removes tube(s) or catheters; aggressive
+2	Frequent non-purposeful movement, fights ventilator
+1	Anxious, apprehensive , but not aggressive
0	Alert and calm
-2	Light sedation, briefly awakens to voice (eye opening/contact) <10 sec

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-3	Moderate sedation, movement or eye opening. No eye contact
-4	Deep sedation, no response to voice, but movement or eye opening to physical stimulation
-5	Unarousable, no response to voice or physical stimulation


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ADULT NONVERBAL PAIN SCALE

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CATEGORIES	0	1	2
Physiology (vital signs)	Stable vital signs	Change in any of the following: *SBP >20 mmHg *HR >20/minute	Change in any of the following *SBP>30mmHg *HR>25/minute
Face (movement)	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead	Frequent grimace, tearing, frowning, wrinkled forehead
Activity	Lying quietly, normal position	Seeking attention through movement or slow, continuous movement	Restless, excessive activity and/or withdrawal reflexes
Guarding	Lying quietly, normal positioning of hands over areas of body.	Splinting areas of the body, tense	Rigid, stiff
Respiratory	Baseline RR/Pulse Oximetry Compliant with ventilator	RR>10 above baseline, or pulse oximetry decreased by 5% or mild asynchrony with ventilator	

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RR>20 above baseline, or pulse oximetry decreased by 10% or severe asynchrony with ventilator

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