DESCRIPTION/OVERVIEW
UNMHSC will provide optimal pain relief & management, realizing this will decrease complications related to painful conditions, help to mitigate side effects associated with treatment, optimize healing & the patient's ability to function.

REFERENCES
- UNMHSC Patient’s Bill of Rights
- New Mexico Pain Relief Act
- A consensus document from the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine. © 2001 American Academy of Pain Medicine, American Pain Society and American Society of Addiction Medicine
- Dewer, A., Mullet, J., Langdeau, S. (2009), Psychiatric Patients: How can we decide if you are in pain? Issues in Mental Health Nursing, 30, 295-303
- ASPNM’s position statement: Pain Management in Patients with Addictive Disease

AREAS OF RESPONSIBILITY
This guideline applies to all areas in the UNMHSC system.

GUIDELINE PROCEDURES
1. Pain is a subjective experience with self-report as the best indicator of the presence and intensity of pain.
2. Pain assessment will be conducted on all patients upon arrival/admission to the hospital, unit or clinic; and when patients condition changes. For inpatients pain assessment will also occur when the care provider changes.
3. Tools utilizing verbal/visual reporting, behaviors, or a combination thereof should be selected based upon evidence of validity and reliability for the appropriate patient population.
4. In keeping with UNMH’s ‘Pain Care Patient Bill of Rights,’ patients and families will be informed that pain relief is an important part of their care. Patients will be informed about options to control pain, and are encouraged to discuss concerns and preferences with the health care team.
5. Prevention of pain is more desirable than treatment of pain. Continuous pain or frequently occurring pain should be treated with around-the-clock (ATC) dosing rather than as needed (PRN). The under-treatment of pain can result in chronic pain conditions. Patients with a history of substance abuse or prior exposure to opioids may require increased analgesic doses.
6. A pain management plan that successfully meets a patient’s goals should follow the patient, especially when the patient transitions to a new unit or team. Adjustments to the plan will be made based on the patient’s/family’s report and the patient’s functional ability related to the
7. Appropriately managed pain leads to improved outcomes. Inappropriately managed pain can result in a variety of negative outcomes such as: delayed wound healing, increased risk of infection, pulmonary complications, hypercoagulability, increased length of stay, lack of or poor restorative sleep, decreased mobility, and decreased patient/family satisfaction.

8. For patients who are unable to self-report, the caregiver must assess the patient for factors that are commonly associated with pain, such as an incision, chest tube, ET tube, fracture, etc. It must be assumed that pain is present if conditions that are frequently associated with pain are present.

9. Reassessment occurs after every intervention, including non-pharmacologic techniques. The characteristics of the intervention/medication and route of administration will dictate the time frame for reassessment.

10. The intramuscular (IM) route should only be used when there is no vascular access. Patients may deny the presence of pain for fear of an injection. IM injections should not be used in children except when the medication cannot be administered by any other route, i.e., vaccinations.

11. Placebo should not be used by any method to assess and/or manage an individual’s pain regardless of their age or diagnosis.

12. Documentation of assessment, specific pain tool used, intervention, and reassessment will be done in the electronic medical record, or the appropriate record for patient’s location in the system.

13. Terminology concerning addiction, tolerance and physical/chemical dependence should be used with caution. Inappropriate use of terminology may result in miscommunication that may influence adequate treatment of pain. (Attachment 1)

**SUMMARY OF CHANGES**
Addition of #2, which denotes when pain assessments are to occur, Clarification of pain assessment tool options, Clarification regarding use of placebo, Addition of attachments: Pain Definitions, Pain Care Patient Bill of Rights
Replaces “Pain”, last revision, 4/2006

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**DOCUMENT APPROVAL & TRACKING**

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**ATTACHMENTS**
Attachment 1: Pain Definitions
Attachment 2: Pain Care Patient Bill of Rights
Pain is an unpleasant sensory/emotional experience that is complex in nature and includes multiple dimensions. “Pain is whatever the person says it is, experienced whenever they say they are experiencing it” (McCaffery & Pasero, 1999). Pain management is based on the needs of the patient.

**Comprehensive pain assessment** – A comprehensive pain assessment is described as an assessment of a patient’s pain that includes the elements of the Pain Assessment Form in the electronic medical record. These include duration, location, laterality, pattern, intensity (use of a pain scale), onset, and quality. This assessment is conducted at every shift change, and/or with a change in patient’s condition, and/or a change in the patient’s caregiver.

In the ambulatory setting a comprehensive pain assessment is described as an assessment of a patient’s pain that includes the following elements: onset, duration, location and intensity (use of a pain scale). This assessment is conducted when the patient is brought to the examination room.

Every patient will be screened for pain. They will be asked if they have pain and if the answer is “yes”, a comprehensive pain assessment will be completed. For patients who answer “no” or deny the existence of pain, a comprehensive pain assessment will not be completed.

**Primary pain** – Primary pain is described as the pain that is most concerning to the patient.

**Secondary pain** — Secondary pain is other pain that was not addressed above but is of concern to the patient.

**General pain** – General pain is any other pain that has not been addressed above.

**Pain reassessment** – Pain reassessment occurs after every intervention. For pharmacologic interventions, reassess within 30 minutes – two hours depending on medication administered and route of administration. For non-pharmacologic interventions reassess as appropriate.

In the ambulatory setting the patients pain will be managed prior to discharge.

**Acute pain** —may be caused by mechanical, thermal or chemical stimuli, i.e., injury, surgery, burns, disease, and inflammation. This type of pain is thought to resolve when tissue injury has healed and was previously defined in terms of brief duration.

**Chronic pain** - Pain that is not attributable to an acute cause, lasting longer than 3 months, with poor relief. Pain that extends beyond the expected period of healing.

The following definitions are taken from the ASPMN Position Statement Pain Management in Patients with Addictive Disease ([www.aspmn.org](http://www.aspmn.org))

**Addiction**: Addiction is a primary, chronic, neurobiologic disease, characterized by behaviors that may include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

**Tolerance**: Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.

**Physical/chemical dependence**: Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

**Pseudo-addiction** - An iatrogenic syndrome created by the undertreatment of pain. It is characterized by patient behaviors such as anger and escalating demands for more or different medications and results in suspicion and avoidance by staff. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated (Weissman & Haddox, 1989).
Pain Care Patient Bill of Rights
Attachment 2
Pain Guideline

As a Person with Pain, you have:

1. The right to have your report of pain taken seriously.

2. The right to be treated with dignity and respect by doctors, nurses and other healthcare team members.

3. The right to have your pain completely assessed and treated quickly.

4. The right to be told by your doctor about what may be causing your pain.

5. The right to be told about all possible treatments for your pain and the benefits, risks and costs of all treatments.

6. The right to have a voice in any decision about how to treat your pain.

7. The right to have your pain assessed regularly.

8. The right to have your treatment changed if your pain does not get better.

9. The right to be sent to a pain specialist if your pain does not go away.

10. The right to get clear and quick answers to your questions about pain.

11. The right to take your time to make decisions about treatments for your pain and the right to refuse a treatment if you choose.

12. The right of privacy regarding any treatment decision you make or refuse.

PFEC 5/2002
F-K 5.9
Adapted from American Pain Foundation, 2001
American Academy of Pain Management, 2002