I. Assessment
   a. Assess pain using organization-approved assessment tools appropriate for the patient's age, medical condition, and ability to understand use of the scale. See Pain Assessment Tools
   b. Use the same assessment tool consistently with each patient unless the patient's condition requires a change in assessment tool.
   c. Numeric Pain Scale and Faces Pain Scale-Revised provide pain intensity scores.
   d. Behavior based scales (NIPS, FLACC, CPOT, PAINAD, etc.) do not provide a pain intensity score. Because the behaviors being evaluated are not specific to pain, any score greater than zero can indicate the possibility of the presence of pain.
      i. Assess the patient to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
      ii. Reassess following interventions. If the score decreases, continue the plan of care. If the score does not decrease, look for other sources of discomfort or distress and modify the plan of care accordingly.

II. Reassessment
   a. Reassessment includes pain intensity/score, adverse effects, and sedation (for patients receiving opioid analgesics).
   b. Reassess once a sufficient time has elapsed for the treatment to be effective. For pharmacologic interventions, timing of reassessment should consider drug, dose, and route.
      i. Suggested reassessment is 15-30 minutes after IV administration and 60-120 minutes after oral administration.
   c. Reassess more frequently for patients experiencing severe, rapidly changing pain and patients exhibiting excess sedation.
   d. Reassess with any new patient report of pain or following a pain-producing event.

III. Assessment When the Patient Appears to be Sleeping
a. Patients receiving opioid analgesics are at highest risk for opioid-induced respiratory depression during the first 24 hours of treatment and occurs more frequently between the hours of 2300 and 0700 when most patients are sleeping (Jarzyna, et al. 2011; Pasero, 2009).

b. Patients receiving opioid analgesics should be awakened for reassessment during the first 24 hours of opioid therapy.

c. The nurse must consider a patient's need for sleep along with patient safety when determining whether or not to wake a sleeping patient.

d. The nurse may use discretion to not wake the patient if respiratory rate (RR) and quality (depth and regularity) are WNL for the patient.

e. If the patient appears to be sleeping:
   i. Observe the patient without stimulation.
   ii. Assess the patient's RR and quality. RR should be counted for a full minute.
   iii. Compare RR and quality to patient's baseline status. **Shallow respirations, periods of apnea, and snoring require immediate attention and further evaluation.**
   iv. Call out the patient's name in a normal tone of voice.
      1. If the patient does not arouse and RR and quality are WNL for the patient, pain assessment/reassessment can be delayed until the patient wakes and "sleep" should be charted. Additionally, RR and quality should be charted.
      2. **If the patient's RR and quality are not WNL, the patient must immediately be stimulated/awakened to complete more thorough pain, sedation, and respiratory assessments.**

f. RR alone is not sufficient to assess for respiratory depression. Assessing quality (regularity and depth) is necessary to determine if the patient is experiencing clinically-significant respiratory depression. A patient may breathe at a rate of 8-10 breaths per minute and be well ventilated if the quality is regular and deep. On the other hand, a patient with a RR of 16 with shallow respirations may not be ventilating adequately.

IV. **Sedation assessment**

a. Sedation and respiratory depression occur on a continuum. Sedation always precedes opioid-induced respiratory depression.

b. The hallmark of clinically significant sedation is the inability of the patient to stay awake to maintain conversation.

c. Assess sedation using a sedation scale appropriate to patient population.

d. Assess sedation prior to and after opioid administration; timing of reassessment is based on drug, dose and route administered.
   i. Reassess more frequently during the first 24 hours of opioid therapy.
   ii. Reassess sedation, including respiratory status, more frequently with advancing sedation.
iii. Assessment may be more frequent in select patient populations by clinician order.

iv. Patients at risk for respiratory depression require more frequent sedation and respiratory assessments. (See section on risk assessment.)

e. RR and quality is assessed with advancing sedation and when the patient appears to be sleeping.

f. Communicate sedation status during hand-off communications.

g. Nursing Update - *Sedation Assessment with Opioid Administration*

V. Risk assessment

a. Screen patients for respiratory risk factors according to local policy.

b. STOP BANG is a validated tool used to screen for obstructive sleep apnea.

c. Many factors increase a patient's risk for developing oversedation and opioid-induced respiratory depression including (Pasero, 2014; TJC, 2012):
   - Obstructive sleep apnea, sleep disordered breathing, or snoring.
   - Obesity e.g., BMI > 30 kg/m2
   - Advanced age, elderly
   - Smoker (> 20 pack years)
   - Preexisting pulmonary or cardiac disease or dysfunction e.g., COPD, CHF
   - Major organ failure e.g., renal or hepatic
   - Opioid naïve, continuous infusion of opioid in an opioid naïve patient
   - First 24 hours of opioid therapy, increased opioid dose requirement
   - Prolonged general anesthesia
   - Thoracic, upper abdominal, or other large incisions that may interfere with adequate ventilation
   - Concomitant administration of sedating medications such as benzodiazepines, antihistamine, sedatives, or other CNS depressants
   - Receiving continuous opioid infusion, particularly with opioid naïve patients

d. Consider risk factors when developing the plan of care e.g., encourage use of scheduled non-opioid multimodal analgesia, maximize use of integrative therapy, reduced opioid dose, avoid continuous infusion rates, etc.

e. Consider enhanced monitoring for higher risk patients according to local policy e.g., capnography, pulse oximetry, more frequent sedation assessment, etc.

VI. Pain management goals

a. Pain goals are determined by the patient and should not be limited to pain intensity ratings; goals must consider function and the overall treatment plan for the patient.

b. It is not realistic to be pain free. Help the patient identify realistic goals based on their treatment goals for the day e.g. participate in therapy, ambulate, and ADLs.

c. **Therapeutic Activity Goal (TAG)** – Functional goals that consider baseline level of
function and the level of desired activities (mobility, ADLs, and psychosocial function) identified according to the patient’s treatment plan and individual patient needs. TAG also includes the **acceptable level of pain** for the patient to meet their functional goals.

d. To assist the patient to identify TAG, engage the patient in a discussion of the following:
   i. What activities and treatments are planned for you today?
   ii. Consider your need to rest and sleep to help with your recovery.
   iii. What level of pain would allow you to do these activities?

e. Communicate TAG through bedside shift report and use of the communication board.

f. Document acceptable level of pain to meet TAG in the EHR.

g. For patients with persistent pain, help them set realistic goals for acute pain based on their baseline level of pain and function.

h. Avoid using the word tolerable. The goal is to manage pain and not just tolerate the pain.

   i. Reassure the patient and family you will do everything possible to manage their pain.

VII. Patient Education

a. Instruct patient on use of pain scales, how to report pain, setting realistic pain goals, pain treatment options, and safe use of opioid and non-opioid medications when prescribed. Discuss patient role in pain management including responsibility to report their pain in a timely fashion. A patient education sheet, *Pain Management*, is available and appropriate for use on admission for any patient presenting with pain.

b. Provide patient and family education on discharge plans related to pain management including the following:
   i. Pain management plan of care
   ii. Side effects of pain management treatment
   iii. Activities of daily living (ADLs), including home environment, that might exacerbate pain or reduce effectiveness of the pain management POC, as well as strategies to address these issues
   iv. Safe use, storage, and disposal of opioids when prescribed.
   v. *Managing Your Pain at Home* is available to assist with discharge education and is appropriate for all patients experiencing pain, not just those that received an opioid prescription.

**Additional resources:** Aromatherapy Toolkit; Ascension WI Pain Management LibGuide; Ascension WI Opioid Guideline LibGuide

**References**


Attachments: No Attachments

Approval Signatures

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<tr>
<td>Peggy Lutz: Srvc Line Pain Mgmt Dir</td>
<td>1/3/2019</td>
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Applicability

Affinity Health System, Affinity Medical Group, Ascension All Saints Hospital, Ascension Calumet Hospital, Ascension Eagle River Hospital, Ascension Good Samaritan Hospital, Ascension NE Wisconsin-Mercy Campus, Ascension NE Wisconsin–St. Elizabeth Campus, Ascension Our Lady of Victory Hospital, Ascension SE Wisconsin Hospital-Franklin Campus, Ascension SE Wisconsin Hsptl–Elmbrk/St Josph Cmpus, Ascension Sacred Heart-St. Mary's Hospitals, Ascension St. Clare's Hospital, Ascension St. Francis Hospital, Ascension St. Michael's Hospital, Ascension Wisconsin, Columbia St. Mary's Hospital Milwaukee, Columbia St. Mary's Hospital Ozaukee, Howard Young Medical Center, Midwest Orthopedic Specialty Hospital, Ministry Health Care, Ministry Medical Group, Ministry Spirit Medical Transportation, Sacred Heart Rehabilitation Institute, Saint Elizabeth's Medical Center, Wheaton Franciscan Healthcare-Southeast Wisconsin, Wheaton Franciscan Medical Group