PAIN ASSESSMENT AND MANAGEMENT

CLINICAL PRACTICE GUIDELINES

Winnipeg Regional Health Authority
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INTRODUCTION

The Pain Assessment and Management Clinical Practice Guideline (CPG) is a tool that has been developed by regional pain experts and provides specific evidence-informed recommendations to assist health care providers in conducting high quality patient pain assessments that will lead to effective pain management.

BACKGROUND

In October 2010 a committee of health care professionals with expertise in clinical practice and research in pain assessment and management from the acute care, personal care, palliative care, oncology and long term care sectors, convened to revise the WRHA Pain Assessment and Management Clinical Practice Guideline (November 2008 version). This committee reviewed recent pain literature and clinical practice guidelines. The committee decided to adopt the Registered Nurses Association of Ontario (RNAO) updated Assessment and Management of Pain 2007 guidelines (RNAO, 2007) as well as incorporate the most recent evidence-informed and valid assessment documentation tools.

SCOPE

This clinical practice guideline is intended to guide assessment and management of pain within the WRHA.

- To provide regional guidelines for pain assessment and management based on current evidence and expert opinion.
- To ensure pain assessment and management is prompt, appropriate and consistent.
- To ensure pain assessment includes the use of systematic and validated tool(s).
- To promote continual monitoring and improvement in patient outcomes in pain management.
- To provide the foundation upon which health care provider education should be based.

GOALS

- To provide regional guidelines for pain assessment and management based on current evidence and expert opinion.
- To ensure pain assessment and management is prompt, appropriate and consistent.
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GUIDING PRINCIPLES

- Effective pain assessment and management requires coordinated interdisciplinary intervention in collaboration with patients and their families.
- Patients have the right to appropriate assessment and management of pain.
- Unrelieved pain has consequences and should be prevented where possible.
- Unrelieved pain requires urgent treatment.
- Pain is a subjective, multidimensional and highly variable experience for everyone, and requires a critical analysis of pain-related factors and interventions.
- A multi-modal treatment approach that includes pharmacological and non-pharmacological interventions is recommended.
- Health care providers are professionally and ethically obligated to advocate for change in the treatment plan when pain relief is inadequate.
- Ongoing education is essential to maintain clinical competency in pain assessment and management.
- Health care providers must advocate for policy change and resource allocation that support effective pain management to improve a patient's quality of life and reduce their suffering.

GLOSSARY OF TERMS

Aberrant Dependence (AKA psychological dependence or addiction)

Displaying aberrant use of medication, causes can include: pseudoaddiction, addiction, diversion, inadequate understanding or instruction or chemical coping.

Acute Pain

The normal, predictable, appropriate response to a noxious stimulus or disease process that threatens or produces tissue injury, and that abates following remission of the stimulus or healing of the injury.

Addiction

Is a chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Adjuvant Co-Analgesics

Nonopioid medications that enhance the analgesia provided by analgesics through mechanisms aimed at the source of transmission of pain, resulting in better pain control and/or fewer adverse effects than treatment with analgesics alone.

Adverse Effect

Can be termed as "side effect" when judged to be secondary to a main or therapeutic effect but also refers to an unpleasant symptom or event that is due to or associated with a medication such as impairment decline in the individual's mental or physical condition, and/or functional or psychosocial status.

Breakthrough Pain

A transitory flare of pain of moderate to severe intensity occurring on a background of otherwise controlled pain.

Cancer Pain

Results from the treatment for cancer or from the cancer itself. Cancer pain depends upon the type of cancer, the stage (extent) of the disease, and the pain threshold (tolerance for pain) of the patient with cancer.

Ceiling Effect

The property of increasing doses of a given medication to have progressively smaller incremental effect.

Chronic Pain (AKA persistent pain)

Pain that persists beyond the usual course of an acute illness or healing time of an injury (usually beyond three to six months), associated with a pattern of recurrence over months or years or associated with a chronic pathological process. It is often accompanied by emotional (depressive) symptoms but objective physiological signs are sometimes absent.

Consultation

Is an evaluation of a patient with recommended treatment options with the patient, then returning to primary care of physician for implementation of recommendations.

Incident Pain

Pain which comes on as a result of an action or activity (such as planned turns, transfers/ambulation, bathing, changing clothes, dressing changes, disimpaction).

Incomplete Cross-Tolerance

A person who has been taking an opioid for an extended period of time may develop a degree of tolerance to it; however, when converting to another opioid, only a part of this tolerance may carry over to the new drug. Therefore, after calculating the required dose of the new drug to achieve an equianalgesic effect, the dose may need to be lowered by up to 50%. Because it is difficult to predict on an individual basis what the equianalgesic dose should be, any opioid conversion requires close monitoring.

Multidimensional

A comprehensive pain assessment must include the physical, psychological, social, cultural and spiritual components of pain (AKA Total Pain).

Multi-Modal Treatments

Is related to, having, or utilizing more than one mode or modality. For example, multi-modal pain management involves a variety of approaches including medications, behavioral and cognitive strategies.

Neuropathic Pain

Pain caused by a lesion or disease of the somatosensory nervous system. Neuropathic pain is divided into 'peripheral' (originating in the peripheral nervous system) and 'central' (originating in the brain or spinal cord). Neuropathic pain is often described as "burning, tingling, electrical, stabbing or pins and needles".

Nociceptive Pain

Arises from stimulation of pain receptors within tissue, which has been damaged or involved in an inflammatory process. Nociceptive pain may be divided into:

a) Somatic pain - generally well-localized pain that results from the activation of peripheral nociceptors without injury to the peripheral nerve or central nervous system, characterized by sharp, hot or stinging pain which is usually localized to the area of injury.

b) Visceral pain - results from the activation of nociceptors of the thoracic, pelvic, or abdominal viscera. It is felt as a poorly localized aching or cramping sensation and is often referred to cutaneous sites.

Non-pharmacological methods

Includes such techniques as superficial heat and cold, massage, relaxation, imagery, prayer/spiritual practices, pressure or vibration, and therapeutic communication.

Opioids

Class of drugs originally derived from the opium poppy that are generally prescribed to manage pain.

Opioid-Induced Neurotoxicity

Is a multifactorial syndrome that causes a spectrum of symptoms from mild confusion or drowsiness to hallucinations (often visual or tactile), delirium, hyperalgesia (an increased sensitivity to pain), allodynia (pain due to a stimulus which does not normally provoke pain such as light touch or rubbing), sedation, and myoclonus (characterized by 'muscle jerking' that can be localized or generalized). If very severe, these can go on to become generalized seizures. Patients with renal impairment and patients on opioids with active metabolites appear to be at a higher risk.

Patient

Refers to patient, resident, and/or client.

Physical Dependence

A state of adaptation manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood levels of the drug, and/or administration of an antagonist. Physical dependence can develop within several days.

Pseudoaddiction

Is a term that describes patient's behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch" and may otherwise seem inappropriately "drug seeking". Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

Referral

Patient is being sent to a specialist for not only evaluation, but for ongoing care with little or no long-term involvement by the primary care (referring) physician.

Suffering

Is severe distress associated with events that threaten the patient's perception of wholeness, is identified within the spiritual dimensions of quality of life but it transcends all dimensions, often occurring when pain is not controlled.

Tolerance

Is a physiological state characterized by a decrease in the effects of a drug (e.g. analgesia, nausea, or sedation) with chronic administration.

EVIDENCE

This document is based on a compilation of published Clinical Practice Guidelines on pain assessment and management as well as review and feedback from local expert opinion. This Clinical Practice Guideline should be perceived as reflecting the current state of knowledge in the field of pain assessment and management.

Best practice demands that health care providers be guided by best available evidence. The grading system used in this guideline has been adapted from the Canadian and U.S. Preventive Task Force Review. Levels of evidence are graded on strength of the scientific evidence. For the purpose of CPG development, data was classified as:

Class I evidence: Prospective randomized controlled trials (PRCTs) - the gold standard of clinical trials.

Class II evidence: Clinical studies in which data were collected prospectively and retrospectively analysis, which were based on clearly reliable data. These types of studies include observational studies, cohort studies, prevalence studies and case control studies.

Class III evidence: Most studies based on retrospective collected data. Examples include clinical series, databases or registries; care reviews, case reports and expert opinion. Examples include: observational studies, cohort studies, prevalence studies and case controlled studies.

In order to understand the strength of the evidence, each recommendation has been cited with a level of recommendation, as follows:

Level 1 This recommendation is convincingly justifiable on the available scientific information alone. It is usually based on Class 1 data; however strong Class II data evidence may form the basis for level 1 recommendation, especially if the issue does not lend itself to testing in a randomized format.

Level 2 This recommendation is reasonably justifiable by scientific evidence and strongly supported by expert opinion. It is usually supported by Class II data or a preponderance of Class III evidence.

Level 3 This recommendation is supported by available data but adequate scientific evidence is lacking. It is generally supported by Class III data. This type of recommendation is useful for educational purposes and in guiding future studies.

RECOMMENDATIONS

PART A – PAIN ASSESSMENT

RECOMMENDATION 1: SCREENING FOR PAIN

Routinely screen all patients for pain by asking about the presence of pain. Pain terminology typically used by the patients to describe the pain such as the use of the word "ache", "hurt" and/or "discomfort" should be assessed and the term used in the ongoing assessment.

Screening should occur at first contact and be repeated as indicated depending on the person's condition, setting, care goals, etc.

Pain assessment should be considered the 5th vital sign.

Level of Recommendation = 1

RECOMMENDATION 2: PAIN ASSESSMENT SOURCES

Self-report should be used as the primary source of assessment. Family and healthcare provider reports of pain are included for children and adults unable to give self-report. Pain assessment should also include assessment of behavioral indicators of pain for non-verbal individuals.

Level of Recommendation = 1

RECOMMENDATION 3: PAIN ASSESSMENT PARAMETERS

Select a systematic pain assessment tool(s) (Appendix A) to assess the parameters of pain, which include:

- Location and radiation;
- Onset, duration and timing;
- Quality and pattern;
- Precipitating factors (multidimensional);
- Aggravating or alleviating factors (multidimensional);
- Patient's description of current pain and its history;
- Intensity and acceptable level of intensity at rest and with movement;

Level of Recommendation = 2

RECOMMENDATION 4: PAIN INTENSITY RATING TOOLS

The selection of an appropriate pain assessment tool is based on its suitability of use with the patient population. The same tool should be used each time pain is assessed. (Appendix B)

Level of Recommendation = 3

RECOMMENDATION 5: COMPREHENSIVE PAIN ASSESSMENT PARAMETERS

The following parameters are part of a comprehensive pain assessment (Appendix C):

- Physical examination, relevant laboratory and diagnostic data (in keeping with patient's goals of care):
- Effects and understanding of current illness;
- History of pain;
- Effects on activities of daily living;
- Physiological and behavioral indicators of pain;
- All past and current treatments for pain, their effectiveness, and their adverse effects;
- Meaning of pain and distress caused by the pain (current and previous);
- Coping responses to stress and pain;
- Multidimensional effects;
- Situational factors – culture, language, ethnic factors, economic aspects of pain and treatment;
- Patient's preferences and expectations/beliefs/hopes/myths about pain management methods;
- Patient's preferences and response to receiving information related to his/her condition and pain; and
- Displaying aberrant/physical dependence, addiction, pseudoaddiction and tolerance (use a screening tool for addiction risk - in Appendix A).

Level of Recommendation = 3

RECOMMENDATION 6: PAIN REASSESSMENT - TIMING

Reassess pain on a regular basis according to the type and intensity of pain and the treatment plan.

- Pain is reassessed at each new report of pain, any change in the presentation of pain, and when pain is not relieved by previously effective strategies.
- Pain is reassessed after the intervention has reached peak effect (eg. for opioids: 15-30 minutes after parenteral opioid therapy; 1 hour after immediate release oral analgesic). This is a general guideline depending on the patient and medication.
- Acute post-operative pain should be regularly assessed as determined by the operation and severity of pain, with each new report of pain or instance of unexpected pain, and after each analgesic, according to peak effect time.

Level of Recommendation = 2

RECOMMENDATION 7: PAIN REASSESSMENT - PARAMETERS

Include the following parameters in the regular re-assessment of pain:

- Current pain intensity, quality and location;
- Intensity of pain at its worst in past 24 hours, at rest and on movement;
- Extent of pain relief achieved – response (reduction on pain intensity rating scale);
- Barriers to implementing the treatment plan;
- Effects of pain on activities of daily living (ADL), sleep, mood and cognition;
- Adverse effects of medications for pain treatment (eg. nausea, constipation, sedation, confusion);
- Displaying aberrant/physical dependence, addiction, pseudoaddiction, tolerance;
- Strategies used to relieve pain, both pharmacological and non-pharmacological.

Level of Recommendation = 2

RECOMMENDATION 8: ASSESSMENT OF UNEXPECTED INTENSE PAIN

Immediately assess unexpected intense pain, particularly if sudden, associated with altered vital signs (e.g. hypotension, tachycardia, fever, dyspnea) or associated with changes in function, mobility, and/or behavior.

Level of Recommendation = 2

RECOMMENDATION 9: DOCUMENTATION OF PAIN ASSESSMENT

Document pain assessment regularly and routinely on standardized forms that are accessible to all clinicians involved in care.

Teach patients and families (as proxy recorders) to document pain assessment on the appropriate tools when care is provided. This will facilitate their contributions to the treatment plan and will promote continuity of effective pain management across all settings.

Level of Recommendation = 3

RECOMMENDATION 10: ADVOCATE FOR PAIN CONTROL

Advocate on behalf of the patient for changes to the treatment plan if pain is not being relieved and/or support the patient to advocate on their own behalf. The health care provider will engage in discussion with the interdisciplinary health care team regarding identified need for change in the treatment plan. The health care provider supports his/her recommendations with appropriate evidence, providing a clear rationale for the need for change which can include:

- Intensity of pain using a validated scale;
- Change in severity of pain scores in last 24 hours;
- Change in severity and quality of pain following administration of analgesic and length of time analgesic is effective;
- Amount of regular and breakthrough pain medication taken in last 24 hours;
- Patient's goals for pain relief;
- Effect of unrelieved pain on the patient;
- Absence/presence of adverse effects or toxicity; and
- Suggestions for specific changes to the treatment plan that are supported by evidence.

Level of Recommendation = 2

PART B – PAIN MANAGEMENT

Establish a Plan of Care

RECOMMENDATION 11: ESTABLISH A PLAN

Establish a written plan for pain management in collaboration with interdisciplinary team members that is consistent with the patient and family goals for pain relief, comfort and function, taking into consideration the following factors:

- Assessment findings;
- Baseline characteristics of pain;
- Multidimensional factors shaping the experience of pain;
- Most effective pharmacological and non-pharmacological interventions;
- Management interventions;
- Current and future primary treatment plans; and
- Patient/family preferences and perceptions.

Level of Recommendation = 2

Select Appropriate Analgesic

RECOMMENDATION 12: ANALGESIC LADDER

Use the Analgesic Ladder (Appendix D) to select the appropriate analgesic. Select the analgesic based on the highest likelihood of gaining pain relief with the lowest likelihood of adverse effects.

Ensure that the selection of analgesics is individualized to the patient, taking into account:

- The type of pain (eg. cancer, acute, chronic, non-cancer, nociceptive and/or neuropathic);
- Intensity of pain;
- Allergies;
- Potential for analgesic adverse effects (consider age, respiratory, renal or hepatic impairment, and if opioid naïve);
- General functional status of the patient;
- Concurrent medical conditions;
- Other medications;
- Response to prior or present medications;
- Financial cost, availability of medications
- Patient's preferences;
- Route of administration;
- Feasibility of use within setting of care and;
- Patient's risk factors related to the potentially aberrant use of opioids, physical dependence, addiction, pseudoaddiction and tolerance.

Level of Recommendation = 2

RECOMMENDATION 13: MULTI-MODAL THERAPY

Consider the addition of other medications in the management plan. Use the appropriate adjuvant co-analgesic drugs to optimize the treatment of neuropathic and/or mixed pain and function such as non-steroidal anti-inflammatory drugs, corticosteroids, anticonvulsants, antidepressants, bi-phosphonates, cannabinoids.

Using agents in combination can offer advantages such as:

- Lower doses of some agents, thus reducing the risk of adverse effects;
- Inhibition of nociceptive processing at multiple (i.e. peripheral and central) levels, thus enhancing analgesia;
- Reduction of pain in patients who do not respond to a single agent.

Level of Recommendation = 2

RECOMMENDATION 14: TRANSDERMAL FENTANYL (AS PER THE FENTANYL DRUG MONOGRAPH)

Recommendations regarding transdermal fentanyl:

- Should not be used in opioid naïve patients. Patients should be taking and tolerating the equivalent of 60 mg of oral morphine equivalent per day with stable symptoms and expected longer-term pain before initiating the transdermal 25 mcg/h patch;
- Should be reserved for chronic, stable pain. In view of its long duration of action (usually applied for 48-72 hours) and lag between dose adjustment and observed effect, it should not be used for titration of analgesia in unstable pain circumstances;
- There should be an immediate release opioid for breakthrough pain (PRN).
- Dose adjustments should generally not be made more than twice/week;
- Elevated temperature, either with fever or local application of heat such as a heating pad or hot water bottle, can result in a fatal fentanyl overdose due to increased absorption. Caution must be exercised in such situations.

Due to its delayed onset of action, when transdermal fentanyl is first initiated the previous opioid should be continued for an approximate 12 hour overlap time period. This would typically equate to 3 doses of a short-acting opioid given q4h, or a final dose of a long-acting opioid.

Level of Recommendation = 2

RECOMMENDATION 15: MEPERIDINE (DEMEROL®)

Avoid using meperidine:

- Meperidine (Demerol®) is contraindicated in patients with impaired renal function, the elderly, neonates, and infants less than 6 months of age.
- Meperidine (Demerol®) is contraindicated for the treatment of chronic pain and in palliative patients due to the build-up of the toxic metabolite normeperidine, which can cause fatal neurotoxicity with seizures.
- Meperdine (Demerol®) is a restricted drug in the WRHA Drug Formulary.

Level of Recommendation = 2

Determine Dosage & Frequency

RECOMMENDATION 16: DOSE TITRATION

Use principles of dose titration specific to the type of pain to reach the analgesic dose that relieves pain with a minimum of adverse effects according to:

- Age;
- Cause of the pain;
- Individual's response to therapy;
- Clinical condition;
- Concomitant drug use;
- Weight (pediatric);
- Lifestyle and patterns of daily living;
- Known pharmacokinetics and pharmacodynamics of the drugs, such as onset and peak effect; and duration of the analgesic effect;
- Non-opioids have a ceiling effect and may cause significant adverse effects at high doses;
- Most opioids do not have an analgesic ceiling.

Level of Recommendation = 2

RECOMMENDATION 17: OPIOIDS

Use the following principles when selecting, initiating and/or titrating a patient on opioids:

Initiation of Opioids:

- Use an immediate-release preparation;
- The opioid dosage can be titrated upwards until pain relief occurs or limiting adverse effects develop;
- Doses may be increased every 24 hours for persons on immediate release preparations;
- Use regular and/or as needed (PRN) medication dosage as indicated;
- After pain control is stable and the daily opioid requirements are established, consider converting the daily dose to a controlled-release preparation that is given every 8 to 24 hours based on formulation, if longer term pain control is expected to be required.

Titration of Controlled-Release Opioids:

- Patients on a controlled-release opiate should have an immediate release analgesic for breakthrough pain (PRN);
- The total **daily** opioid requirement (sustained release and breakthrough) should be calculated and controlled-release product should be adjusted accordingly;
- Doses may be increased every 48 hours for patients on controlled released opioids.

Acute Pain:

- If severe pain is expected for 48 hours post-operatively, routine administration may be needed for that period of time. Late in the post-operative course, analgesics may be effective given on a PRN basis;
- In an acute pain crisis consider aggressive opioid titration through administration of intravenous boluses followed by a continuous intravenous infusion. A simple increase in an infusion will not achieve steady state for approximately 5 half-lives of the drug (i.e. after approximately 20 hours for morphine); if rapid analgesia is required a loading dose must be administered.

Chronic Pain:

- Opioids are not indicated in all chronic pain conditions, and medication alone is often insufficient to manage chronic pain. Other effective pharmacologic and non-pharmacologic treatments should also be considered.

Level of Recommendation = 2

RECOMMENDATION 18: BREAKTHROUGH DOSES

Promptly treat pain that occurs between regular doses of analgesic (breakthrough pain) using the following principles:

- Breakthrough doses of analgesic in the post-operative situation are dependent on the routine dose of analgesic, the patient's respiratory rate, and the type of surgery, and are usually administered as bolus medications through PCA pumps or epidural route;
- The PRN interval for breakthrough doses should reflect the expected timing of drug effect when given by the specific route: peak time of approximately 15 minutes for intravenous, 30 minutes for subcutaneous injection, and 1 hour for oral administration. Some institutions may be most comfortable with a PRN interval of 1 or 2 hours, however there is no rationale for exceeding 2 hours for a PRN dosing interval;
- It is most effective and safer to use the same opioid for breakthrough pain as that being given for the scheduled dosing in order to minimize incomplete cross-tolerance;
- Reassessment should occur prior to changing the breakthrough dose;
- Breakthrough analgesic should generally be calculated as 10 per cent of the total 24-hour dose of the routine scheduled analgesic. This may need individual titration according to effectiveness, as ultimately the correct breakthrough dose is the one that works;
- Breakthrough analgesic doses should be changed when the scheduled medication is changed, in order to ensure continued proportionality to the total daily opioid dose;
- Consider increasing the scheduled dose if 3 or more breakthrough doses are used in 24 hours;
- Consider decreasing the scheduled dose if pain control is consistently good and no breakthrough doses are being used, particularly if there are dose-dependent adverse effects such as sedation;
- Non-pharmacological methods and adjuvant co-analgesics may be useful in the management of breakthrough pain episodes.

Level of Recommendation = 2

RECOMMENDATION 19: INCIDENT PAIN

Anticipate incident pain and combine pharmacological and non-pharmacological options for prevention.

If sublingual or intranasal fentanyl and sufentanil are used, they must be given 15 minutes prior to the procedure to be effective in preempting incident pain; these drugs tend to peak within 15 minutes.

Level of Recommendation = 2

Establish Route

RECOMMENDATION 20: ROUTES OF ADMINISTRATION

Recognize that no single route of drug administration is appropriate for all clinical situations. Advocate for the use of the least invasive route of administration of pain management modalities. Tailor the route to the individual pain situation taking into consideration the urgency for symptom management, patient preferences, and limitations of the care setting.

- **Oral route** is the preferred route. It is convenient, flexible and associated with stable drug levels with regular administration. A feeding tube is considered an oral route. For patients who cannot swallow capsules or tablets, many opioids are available in oral liquid formulations. Sustained-release opioid medications must not be crushed.
- **Sublingual/buccal route** provides a rapid onset for lipid-soluble medications such as fentanyl and sufentanil, and can be an effective alternative when there are swallowing difficulties.
- **Transdermal route** is a non-invasive alternative means of continuous drug delivery especially if the oral route is inappropriate. Elevated temperature, such as through fever or externally applied heat sources, can dangerously accelerate absorption.
- **Rectal route**, if appropriate, is effective, but consideration must be given to personal dignity and comfort. The rectal route is relatively contraindicated in neutropenia, thrombocytopenia, and rectal pathology.
- **Subcutaneous** (intermittent or continuous) is convenient and equally effective as the intravenous route.
- **Intravenous** (intermittent or continuous) route provides a rapid onset of pain relief. It provides a stable effect that can attain steady blood concentration levels with regular administration. However, in patients with compromised venous access, this route may be difficult to maintain.
- **Interventional analgesia**, such as with spinal (epidural or intrathecal) analgesia or with peripheral nerve blocks, can have a valuable role in pain management, particularly when adverse effects of systemic medications limit dose escalation. Their availability and management is determined by institutional policy.
- **Intramuscular (IM) route** is not recommended as it has multiple disadvantages (e.g. pain, erratic absorption, fluctuating drug levels, tissue fibrosis).
- **Topical route** - There is limited research supporting the effectiveness of analgesics compounded for topical use, however there is anecdotal information indicating effectiveness in some circumstances. Topical route could be considered for locally circumscribed neuropathic or musculo-skeletal pain.
- **Intranasal** - provides rapid absorption, easy to administer. Can be used with certain medications.

Level of Recommendation = 3

Anticipate and Manage Adverse Effects

RECOMMENDATION 21: ADVERSE EFFECTS

Anticipate and monitor patients taking opioids for common adverse effects. Treat adverse effects promptly. Expected adverse effects could include:

- Constipation;
  - Patients starting opioid treatment should be placed on bowel regimens concurrently to avoid constipation.
- Nausea and vomiting (if mild to moderate, usually presents for 1-5 days and then stops)
- Pruritus (itching);
- Urinary retention;
- Dry mouth;
- Mild sedation or fatigue for the first 72 hours following the introduction of an opioid or an increase in dose. For chronic pain these side effects may be present for 1 to 2 weeks;
- Mild hypotension.

The following adverse effects are more severe and require immediate attention by the healthcare team:

- Symptomatic hypotension;
- Fatigue that persists beyond 72 hours;
- Disorientation/delirium;
- Significantly decreased level of consciousness (increasing sedation precedes respiratory depression);
- Respiratory depression – while uncommon when opioids are administered in response to pain and in doses that are proportionate to the degree of distress, respiratory depression can be a life-threatening adverse effect. Typically there is concurrent decreased level of consciousness and miotic (small) pupils, and a history of rapid dose escalation. When suspected, appropriate interventions should be undertaken, including respiratory support if needed and opioid reversal with naloxone (consider gently titrating naloxone in situations of mild respiratory depression to avoid abrupt reversal of analgesia). The half life of Naloxone is 64 minutes. After this period a new assessment should be considered.

Level of Recommendation = 3

RECOMMENDATION 22: MANAGING ADVERSE EFFECTS

Use the following principles to manage adverse effects:

- Counsel patients that adverse effects of opioids can generally be controlled to ensure adherence with the medication regime;
- Recognize that transitory sedation is common and counsel the person and family/care provider that drowsiness is common upon initiation of opioid analgesics and with subsequent dosage increases;
- Recognize and treat all potential causes of adverse effects taking into consideration medications that potentiate opioid adverse effects, including:
  - Sedation - sedatives, tranquilizers, antiemetics,antihistamines;
  - Postural hypotension - antihypertensives, tricyclic antidepressants, phenothiazines;
  - Confusion - phenothiazines, tricyclic antidepressants, antihistamines and other anticholinergics;
- Add a drug that counteracts the adverse effect;
- Change the dosage or route of administration if these are implicated in the adverse effect;
- Try a different drug within the same class;
- Try multi-modal therapy including non-pharmacological interventions.

Level of Recommendation = 3

RECOMMENDATION 23: OPIOID-INDUCED NEUROTOXICITY

Opioid-induced neurotoxicity is generally manifested by a decreased level of consciousness, confusion, hyperalgesia, myoclonus, and seizures (in severe cases). It is a potentially fatal clinical syndrome. Often the first clinical clue is a rapid escalation of opioid doses along with increasing patient restlessness and distress; the increased opioid doses are in fact causing the hyperalgesia. The most common offending opioids are morphine and hydromorphone which have active metabolites. Fentanyl and methadone have no known active metabolites. Patients at high risk for toxicity include those who may have difficulties with renal clearance of opioid metabolites and may include:

- Elderly;
- Persons at end of life;
- Persons with renal impairment.

Use the following principles:

- Monitor patients for signs and symptoms of opioid-induced neurotoxicity;
- Discontinue the offending opioid;
- Opioid metabolite clearance can be augmented through hydration, if this is clinically possible and appropriate;
- In opioid-induced neurotoxicity it is not possible to calculate an appropriate dose of a substitute opioid using standard conversion tables as the hyperalgesia induced by the offending opioid will subside once it is discontinued. It is safest to use a conservative PRN dose of the substitute opioid and titrate to effect. Subsequent regularly scheduled doses can be determined by reviewing the daily opioid needs.
- Strongly consider consulting a pain or palliative care specialist for advice.

Level of Recommendation = 3

Consider Non-Pharmacological Management

RECOMMENDATION 24: NON-PHARMACOLOGICAL MANAGEMENT

Combine pharmacological methods with non-pharmacological methods to achieve effective pain management and:

- Institute educational and psycho-educational interventions as part of the overall plan of treatment for pain management;
- Implement educational and psychosocial interventions that facilitate coping of the patient and family early in the course of treatment;
- Non-pharmacological methods of treatment should not substitute for adequate pharmacological management. Any potential contraindications to non-pharmacological methods should be considered prior to application. Selection of non-pharmacological methods should be based on individual preference, and may include strategies such as:
  - Superficial heat and cold;
  - Massage;
  - Relaxation;
  - Imagery;
  - Prayer/spiritual practices;
  - Pressure/vibration;
  - Music
  - Cognitive /behavioral therapy
  - Consult the Child Life Worker who can assist with distraction during painful procedures
  - Parental/family involvement with a child's pain
  - Positioning infants is an effective pain control technique (i.e. swaddling, cuddling)
  - Sucrose is effective in controlling behavioural responses to pain in infants up to one year (Appendix A).

Level of Recommendation = 3

Refer to Experts

RECOMMENDATION 25: CONSULTATION/REFERRAL

Consult/refer patients whose pain is not relieved after following standard principles of pain management to a specialist skilled in dealing with the particular type of pain and population.

Level of Recommendation = 2

Educate Person and Family

RECOMMENDATION 26: PATIENT/FAMILY EDUCATION

Provide patients and their family/care providers with information about their pain and the measures used to treat it by:

- Ensuring that patients and families are informed of the benefits, risks and possible adverse effects of proposed treatment;
- Ensuring that patients understand the importance of promptly reporting unrelieved pain, changes in their pain, new sources or types of pain, what to do if pain is not relieved and adverse effects of treatment;
- Consider providing patients and families/care providers with a written copy of the treatment plan, and all revisions, to promote their decision-making and active involvement in the management of pain;
- Clarify the differences between addiction, tolerance, pseudoaddiction, and physical dependence to address misconceptions that can prevent optimal use of pharmacological methods for pain management;
- Educate and encourage the patient to take a preventive approach to pain and discomfort by asking for relief measures before pain and discomfort are severe or out of control.
- Teach and encourage patients and families to document pain assessment and the effect of analgesics and any adverse effects using appropriate tools. Patient diaries (Appendix "E") may be considered as a means of assisting patients/families to communicate with the interdisciplinary team.

Level of Recommendation = 3

Evaluate Outcomes

RECOMMENDATION 27: PATIENT OUTCOMES

Evaluate on an ongoing basis whether the patient and family goals for pain relief, comfort and function have been met and maintained.

Modify the plan if the goals have not been met and/or maintained.

Level of Recommendation = 3

Documentation

RECOMMENDATION 28: DOCUMENTATION OF PAIN MANAGEMENT

Document on the patient's record all interventions and outcomes including:

- Effect of pharmacological and non-pharmacological interventions;
- Changes in pain interventions and rationale;
- Patient and/or family/care providers expressed refusal of offered pain relief measures and document reasons for refusal.

Utilize the patient's record to communicate with members of the healthcare team.

Level of Recommendation = 3

EVALUATION & MONITORING THE WRHA PAIN CPG INTO PRACTICE

Stakeholders are encouraged to evaluate the implementation of the Clinical Pain Assessment/Management Guideline for feasibility of practice. Canadian accreditation standards give clear direction to health care facilities that ongoing assessment of the effectiveness of pain management is an expected component of the Accreditation Canada evaluation. Evaluating and monitoring the quality of pain care can be achieved by identifying indicators in three areas, namely, structure, process and outcome components of care (RNAO, 2007).

Structure of Care

Performance data include characteristics of health care professionals and organizations such as training, education, type of facility and ownership indicators;

- Availability and access to practitioners or health care providers identified as pain specialists.
- Qualifications and education of staff in pain assessment and management.
- Organizational commitment to pain relief inclusive of policies and procedures for pain assessment and management, availability of standardized tools for pain assessment and daily pain monitoring, and pain adopted as the fifth vital sign in the health record.
- Availability of appropriate medications and nonpharmacological treatment modalities.

Process of Care

Process data describes the activities of the health care provider in the encounter between the patient and the provider such as tests ordered, medication prescribed, assessments completed and interventions implemented. Process data are considered credible if it can be demonstrated that variations in the attribute measured leads to a difference in outcomes. Process of Care indicators include:

- Chart audits to evaluate the practice of providers in the appropriate assessment and treatment of pain including:
  - Use of comprehensive pain assessment tool;
  - Use of a pain intensity scale to guide treatment and monitor the effectiveness of the treatment modalities;
  - Documentation of pain reassessment;
  - Use of the analgesic ladder and CPG recommendations related to pharmacological and nonpharmacological treatments.
- Pain Relief Scale estimates the change in pain severity as a result of treatment modalities and evaluates the adequacy of pain treatment.
- Pain Management Indexes evaluates the appropriateness of pain treatment by assessing congruence between the type of analgesic prescribed and the patients reported level of pain severity.
- Assessment of knowledge of the health care team in regards to pain assessment and management.
- Evidence of appropriate referrals to pain specialists.

Outcomes of Care

Outcome data refer to the patient's subsequent health status and may include items such as mortality, quality of life, improvement in symptoms or functional status and patient satisfaction. Outcome data indicators include:

- Patient Satisfaction Scale;
- Pain Intensity Scores.

This Committee hopes this work will benefit those patients who require effective pain management to maintain their dignity, functional capacity and overall quality of life.

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APPENDIX A

If you wish to use any of the listed tools please contact the tool developer author for permission.

Below is a listing of Pain Screening/Assessment Tools in use at various WRHA sites.

Children

- For children unable to verbalize presence of pain, screen for pain using one of the following tools:
  - The Faces, Legs, Activity, Cry and Consolability Pain Assessment Tool (FLACC)
  - The FACES (R) Pain Assessment Tool
  - The PIC Comfort Scale (used in Pediatric Intensive Care Unit)
  - HSC - Pain and Sedation Assessment & Management in Newborns Practice Guideline
  - Non-communicating Children's Pain Checklist – Revised (NCCPC-R)
  - Non-communicating Children's Pain Checklist – Post Op Version (NCCPC-PV)
  - The Neonatal Pain, Agitation, & Sedation Scale (N-PASS)
- For children who can communicate the following tools can be utilized:
  - NRS - Numeric rating scale
  - Poker Chip Tool
  - Sucrose for procedural pain in newborns

Adults (unable to verbalize)

- For the patients with communication difficulties/impairment attempt to facilitate communication where possible.
- For patients with dementia ongoing and regular evidence-informed pain assessment is encouraged because under-treatment of pain is frequently reported.
- For adults unable to verbalize the presence of pain, screen for pain using one of the following tools:
  - PACSLAC: The Pain Assessment Checklist for Seniors with Limited Ability to Communicate.
  - Pain Assessment in Advanced Dementia Scale (PAINAD)
  - The Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN)
  - Pain Assessment for the Cognitively/Communicatively Impaired (PACCI)
  - Doloplus2
  - DS-SAT-The Discomfort Scale-Dementia of the Alzheimer's Type
  - Checklist of Nonverbal Pain Indicators

Adults (risk of abuse)

- Adults who are at risk of opioid abuse and/or display aberrant behaviors (excluding pseudoaddictive behaviors) should be screened with the following tools:
  - ORT- Opioid Screening Tool
  - Screener and Opioid Assessment for Patients with Pain (SOAPP-R)

Adults (English not first language)

- Consider using multi-language tools for patients and families where English is not their first language. Please refer to the following websites to view multi-language assessment tools for pain assessment:
  - http://www.mdanderson.org/education-and-research/departments-programs-and-labs/departments-and-divisions/symptom-research/symptom-assessment-tools/brief-pain-inventory.html
  - http://www.britishpainsociety.org/pub_pain_scales.htm

Adults (Intensive Care)

- Adults admitted to an Intensive Care Unit often have undertreated pain and the use of assessment tools could facilitate better pain management:
  - Critical Care Pain Observational Tool

Adults (risk of opioid induced sedation)

- Pasero Opioid-Induced Sedation Scale (POSS)

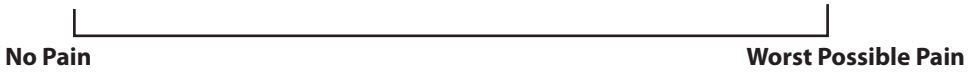
APPENDIX B

PAIN INTENSITY RATING TOOLS

This appendix includes recommended pain intensity rating tools:

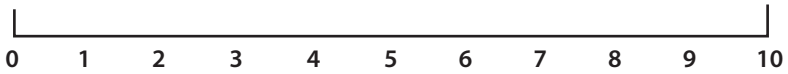
- Visual Analogue Scale (VAS)
- Numeric Rating Scale (NRS)
- Verbal Rating Scale (VRS)
- Present Pain Intensity Scale (PPI)
- Wong-Baker FACES Pain Rating Scale

Visual Analogue Scale (VAS)



The patient indicates intensity of pain on a 10cm line marked from "No Pain" at one end to "Worst Possible Pain" it could be at the other end.

Numeric Rating Scale (NRS)



The patient rates pain on a scale from zero ("0") to ten ("10")

Verbal Rating Scale (VRS)

The patient answers the following question using one of the answers provided:

How strong is your pain?
1. No pain
2. Mild
3. Moderate
4. Severe

Present Pain Intensity Scale (PPI)

The patient answers the following question using one of the answers provided:

How strong is your pain?
1. Mild
2. Discomforting
3. Distressing
4. Horrible
5. Excruciating

Wong-Baker FACES Pain Rating Scale

Wong-Baker FACES™ Pain Rating Scale

©1983 Wong-Baker FACES™ Foundation. Used with permission.

Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the person to choose face that best describes their own pain and record the appropriate number.

Original Instructions: Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.

Face 0 is very happy because he doesn't hurt at all.

Face 2 hurts just a little bit.

Face 4 hurts a little more.

Face 6 hurts even more.

Face 8 hurts a whole lot.

Face 10 hurts as much as you can imagine, although you don't have to be crying to feel this bad.

Ask the person to choose the face that best describes how he is feeling.
Rating scale is recommended for persons age 3 years and older.

APPENDIX C

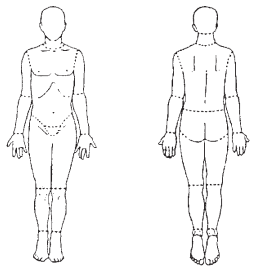
WRHA SAMPLE PAIN ASSESSMENT DOCUMENTATION TOOLS

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

PAIN ASSESSMENT TOOL (Adult)

CLIENT HEALTH RECORD #
CLIENT SURNAME
GIVEN NAME
DATE OF BIRTH
SEX
MHSC #
PHIN #

1. Please mark the area of pain on the drawing. If you have more than one pain, label them A, B, C, etc.



Rate your pain on a scale from 0 to 10.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

DATE _____

	PAIN A	PAIN B	PAIN C
A) Rate your pain on a scale from 0 - 10? • At the present time • At its worst • At its least • Person's acceptable pain level	_____ /10 _____ /10 _____ /10 _____ /10	_____ /10 _____ /10 _____ /10 _____ /10	_____ /10 _____ /10 _____ /10 _____ /10
B) Check the words that best describe the kind of pain you have. Check as many words as apply.	☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Sharp ☐ Stabbing ☐ Deep ☐ Cramping ☐ Surface ☐ Pins and Needles ☐ Other _____	☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Sharp ☐ Stabbing ☐ Deep ☐ Cramping ☐ Surface ☐ Pins and Needles ☐ Other _____	☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Sharp ☐ Stabbing ☐ Deep ☐ Cramping ☐ Surface ☐ Pins and Needles ☐ Other _____
C) Does the pain radiate/travel anywhere?	☐ YES ☐ NO If YES, where _____	☐ YES ☐ NO If YES, where _____	☐ YES ☐ NO If YES, where _____
D) How & when did the pain begin?	_____ _____	_____ _____	_____ _____
E) How often do you have the pain?	☐ All the time ☐ Many times a day ☐ Once a day ☐ Other _____	☐ All the time ☐ Many times a day ☐ Once a day ☐ Other _____	☐ All the time ☐ Many times a day ☐ Once a day ☐ Other _____
F) How long does the pain usually last?	☐ Seconds ☐ Minutes ☐ Hours ☐ Constant	☐ Seconds ☐ Minutes ☐ Hours ☐ Constant	☐ Seconds ☐ Minutes ☐ Hours ☐ Constant
G) What makes the pain worse?	☐ Walking ☐ Dressing Changes ☐ Moving ☐ Other (describe) _____	☐ Walking ☐ Dressing Changes ☐ Moving ☐ Other (describe) _____	☐ Walking ☐ Dressing Changes ☐ Moving ☐ Other (describe) _____
H) Is your pain worse at a certain time of day? When?	☐ Morning ☐ Evening ☐ Afternoon ☐ Night	☐ Morning ☐ Evening ☐ Afternoon ☐ Night	☐ Morning ☐ Evening ☐ Afternoon ☐ Night
I) What makes the pain better?	☐ Heat ☐ Relaxation ☐ Cold ☐ Distraction ☐ Massage ☐ Lying Still ☐ Changing Position ☐ TENS, Physio, Acupuncture ☐ Other (describe) _____	☐ Heat ☐ Relaxation ☐ Cold ☐ Distraction ☐ Massage ☐ Lying Still ☐ Changing Position ☐ TENS, Physio, Acupuncture ☐ Other (describe) _____	☐ Heat ☐ Relaxation ☐ Cold ☐ Distraction ☐ Massage ☐ Lying Still ☐ Changing Position ☐ TENS, Physio, Acupuncture ☐ Other (describe) _____

DRAFT #3 FORM #????? 04/06 Adapted from Calgary Inter-Agency Pain Assessment Tool

SAMPLE

2. What medication(s) are you taking for pain now (Include prescription, non-prescription, herbal, street drugs)? How often are you taking them?

MEDICATION	HOW OFTEN?

3. On average, how much alcohol do you drink in a week? _____
4. What medication(s) best control your pain? _____
5. What medication(s) have not helped? _____
6. Has the pain or treatment caused any other symptoms?
   - ☐ Nausea ☐ Sleep Problems ☐ Anxiety ☐ Loss of Appetite ☐ Problems Thinking
   - ☐ Drowsiness ☐ Diarrhea ☐ Problems with Balance/Falls ☐ Dizziness ☐ Constipation
   - ☐ Change in Mood ☐ Other (describe) _____
7. Does pain affect your:

	YES	NO	Comments
Physical Activity/Walking	☐	☐	
Ability to Care for Yourself	☐	☐	
Social Activities	☐	☐	
Job/Finances	☐	☐	
Parenting	☐	☐	
Intimate/Sexual Relationships	☐	☐	
Religious/Spiritual Beliefs	☐	☐	
Self-Image	☐	☐	

8. What has your doctor told you about the cause of your pain? _____
9. What do you think is the cause of your pain? _____
10. What does the pain mean to you? _____
11. How do you express your pain? _____
12. How do you cope with your pain? _____
13. What concerns do you have about your pain management?
    - ☐ Money to pay for medications ☐ Fear of becoming addicted to pain medications
    - ☐ Side effects of pain medications ☐ Communicating or explaining your pain to others
    - ☐ Getting prescriptions picked up ☐ Need to save some pain medication in case the pain gets worse
    - ☐ Other (describe) _____
14. What concerns do your family and/or caregivers have? _____
15. What do you feel would help you with your pain? _____
16. How do you prefer to get information about your pain/pain management stategies? _____
17. Is there anything else you want to tell us about your pain? _____

Assessor's Observations Relevant to this Pain Problem (e.g. objective assessment, affect, guarding, grimacing, vital signs)

_____

_____

_____

_____

_____

_____

_____
SIGNATURE OF ASSESSOR

SAMPLE

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

PAIN FLOW SHEET

CLIENT HEALTH RECORD #
CLIENT SURNAME
GIVEN NAME
DATE OF BIRTH
SEX
MHSC #
PHIN #

			Date & Time						
Location	Where is the pain?								
	Does pain radiate? *Yes/No*		Y / N						
Intensity	Rate Pain on a Scale of 0 - 10	Worst in past 24 hours	/10	/10	/10	/10	/10	/10	/10
		Best in past 24 hours	/10	/10	/10	/10	/10	/10	/10
		At rest	/10	/10	/10	/10	/10	/10	/10
		On movement	/10	/10	/10	/10	/10	/10	/10
		With dressing changes	/10	/10	/10	/10	/10	/10	/10
Quality	Dull Ache		Y / N						
	Burning		Y / N						
	Stabbing		Y / N						
	Cramping		Y / N						
	Throbbing		Y / N						
	Pins and Needles		Y / N						
	Sharp		Y / N						
	Deep		Y / N						
	Surface		Y / N						
	Other *describe*								
Management Strategies	# of breakthroughs in last 24 hours								
	Use of non-pharmacological interventions *Yes/No Ineffective/Effective*		Y / N I / E						
Side Effects of Pain Medication	Nausea		Y / N						
	Sleep Problems		Y / N						
	Anxiety		Y / N						
	Loss of Appetite		Y / N						
	Problems Thinking		Y / N						
	Drowsiness		Y / N						
	Diarrhea		Y / N						
	Problems with Balance/Falls		Y / N						
	Dizziness		Y / N						
	Constipation		Y / N						
	Change in Mood		Y / N						
	Other *describe*								
Additional Note in IPN			Y / N						
Initials									

SAMPLE

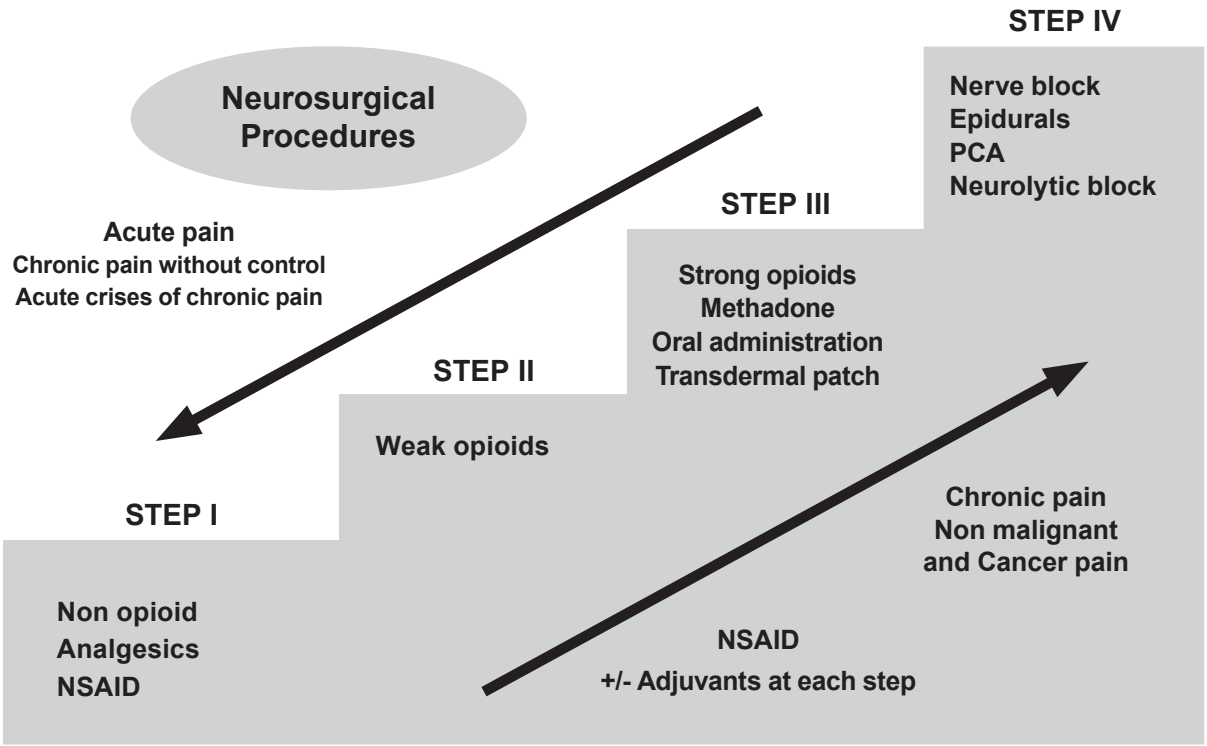
DRAFT #3 FORM #????? 04/06

APPENDIX D

ANALGESIC LADDER

If pain occurs, there should be prompt oral administration of drugs in the following order: nonopioids (acetaminophen, aspirin); then, as necessary, mild opioids (codeine); then strong opioids such as morphine, until the patient is free of pain. To treat neuropathic pain, additional drugs – "adjuvants" – should be used. To maintain freedom from pain, drugs should be given "by the clock", respecting pharmacological half life of the analgesic selected (that is every 3-6 hours), rather than "on demand". This three-step approach of administering the right drug in the right dose at the right time is inexpensive and 80-90% effective. Surgical intervention on appropriate nerves may provide further pain relief if drugs are not wholly effective. Vargas-Schaffer (2010) suggests the adaptation of the original WHO ladder to include: the treatment of acute, chronic, noncancer, cancer and pediatric pain, the addition of a fourth step, the new opioids, and can be used in a bidirectional fashion: the slower upward pathway for chronic pain and cancer pain, and the faster downward direction for intense acute pain, uncontrolled chronic pain, and breakthrough pain.

WHO Analgesic Ladder (Reproduced with permission):



PCA (Patient Controlled Analgesia)
NSAID: Non Steroidal Anti-Inflammatory Drugs

Reprinted with Permsission. G. Vargas-Schaffer. (2010). Is the WHO analgesic ladder still valid?: Twenty-four years of experience. *Canadian Family Physician*, 56(6), 514-7.

APPENDIX E

PAIN DIARIES

Some examples of Pain Diaries in use around the WRHA:

- Deer Lodge Centre: Patient/Resident Pain Diary
- CancerCare Manitoba: Pain and Symptom Management Diary
- Canadian Virtual Hospice: Symptom Diary
  http://www.virtualhospice.ca/Assets/cvh%20symptom%20diary_20090429144800.pdf

Example of Pain Education Manual for Patients:

Canadian Pain Coalition:
http://prc.canadianpaincoalition.ca/fr/patient_pain_manual.html