Complete Summary

GUIDELINE TITLE

Assessment and management of pain.

BIBLIOGRAPHIC SOURCE(S)

Registered Nurses Association of Ontario (RNAO). Assessment and management of pain. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2002 Nov. 142 p. [109 references]

Registered Nurses Association of Ontario (RNAO). Assessment and management of pain: supplement. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007 Feb. 27 p. [63 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.

COMPLETE SUMMARY CONTENT

IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Acute and chronic pain

GUIDELINE CATEGORY

Evaluation
Management
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Geriatrics
Nursing
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Nurses

GUIDELINE OBJECTIVE(S)

- To present nursing best practice guidelines on the assessment and management of pain, including prevention of pain wherever possible
- To provide specific recommendations for specialized populations such as the elderly and children
- The February 2007 supplement should be used in conjunction with the original guideline as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

TARGET POPULATION

Patients of all ages and in all care settings with or at risk of acute or persistent pain

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation/Screening

1. Screening persons at risk for pain

2. Pain assessment, including: eliciting patients' self-report, use of pain assessment tools (Visual Analogue Scale [VAS], Numeric Rating Scale [NRS], Verbal Scale, Faces Scale, Behavioural Scale); and assessment for physiological and behavioural indicators of pain
3. Comprehensive pain assessment (physical examination, relevant laboratory and diagnostic tests, effect and understanding of current illness, history of pain, meaning of pain and distress caused by pain; coping responses to stress and pain, effects on activities of daily living; psychosocial and spiritual effects, psychological effects; situational factors, person's preferences and expectations/beliefs/myths, person's preferences and response to receiving information intended to his/her condition and pain).
4. Reassessment and ongoing assessment of pain
5. Documentation of pain assessment
6. Communicating findings of a pain assessment

Management

1. Establishing a plan for pain management
2. Provide individuals and family-care providers with a written copy of the treatment plan
3. Pharmacological management of pain:
    - Selecting appropriate analgesics in a step wise approach
    - Analgesics, such as acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDS), and opioids
    - Consultation with pain management expert for complex situations
    - Adjuvant drugs, such as anticonvulsants, non-steroidal anti-inflammatory drugs (NSAIDS), and antidepressants for specific types of pain
    - Measures to optimize pain relief with opioids
    - Monitoring for safety, efficacy, adverse effects, and toxicities of medications
    - Anticipation and prevention of common adverse effects of opioids
    - Anticipation and prevention of procedural pain
    - Patient and family education regarding pain and prevention and treatment of medication side effects
    - Effective documentation
4. Non-pharmacological management of pain (e.g. superficial heat and cold, massage, relaxation, imagery, pressure or vibration, psychosocial interventions, cognitive-behavioral strategies combined with a multidisciplinary rehabilitative approach)
5. Education, organization and policy strategies and approaches

MAJOR OUTCOMES CONSIDERED

- Effectiveness of pain relief strategies
- Safety and adverse effects of medications used to manage pain

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

November 2002 Guideline

A systematic literature search in addition to a structured Internet search yielded a set of ten clinical practice guidelines related to the assessment and management of pain.

A quality appraisal was conducted on ten identified clinical practice guidelines using a tool from Cluzeau et al. (1997). This tool provides a framework for assessing the quality of clinical practice guidelines and facilitates the decision-making process. Refer to the original guideline document for details (see "Guideline Availability" field in this summary).

From this systematic evaluation, four documents were identified as high quality, relevant guidelines appropriate for use in the development of this best practice guideline. Specifically, they were strong in rigour and context/content which the panel identified as being important in terms of the data they required. These guidelines included:

- Agency for Health Care Policy and Research (AHCPR) (1992). Acute pain management: Operative or medical procedures and trauma. Clinical Practice Guideline, Number 1. AHCPR Publication Number 92-0032. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.
- Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical Practice Guideline, Number 9. AHCPR Publication Number 94-0592. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services.
- American Pain Society, Quality of Care Committee (1995). Quality improvement guidelines for the treatment of acute and cancer pain. Journal of the American Medical Association, 274(23), 1874-1880.
- Royal College of Nursing (1999). Clinical practice guidelines – The recognition and assessment of acute pain in children, Technical report. London: Royal College of Nursing.

A quality appraisal was conducted on ten identified clinical practice guidelines using a tool identified in the original guideline document. This tool provides a framework for assessing the quality of clinical practice guidelines and facilitates the decision-making process. Refer to the original guideline document for details.

February 2007 Supplement

Members of the panel critically appraised seven guidelines on the topic of pain assessment and management, using the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument. From this review, two guidelines were identified to inform the revision process. These guidelines were:

- American Pain Society. (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS).
- Institute for Clinical Systems Improvement (2006). Assessment and management of acute pain. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI).

NUMBER OF SOURCE DOCUMENTS

November 2002 Guideline

Not stated

February 2007 Supplement

The literature search yielded 1165 abstracts. One hundred eighteen studies met inclusion criteria. Two guidelines were identified to inform the revision process.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In June of 2000, a panel of nurses with expertise in clinical practice and research in pain assessment and management in the acute, chronic, palliative and pediatric pain population, from both institutional and community settings, convened under the auspices of the Registered Nurses Association of Ontario (RNAO).

The development panel developed a synthesis table of the recommendations from the four selected clinical practice guidelines. Practice recommendations were extracted or adapted from those guidelines that ranked the highest in rigour,

context and content, and application (first round). A second round of practice recommendations were extracted from those guidelines which had high ratings for content or where content was relevant and could be supported by existing literature. The panel adapted practice recommendations within these guidelines in order to ensure their applicability to best nursing practice. Systematic and narrative reviews of the literature were used in the development of practice recommendations that could not be extracted from existing guidelines. Panel consensus was obtained for each recommendation.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Grades of Recommendations

The grading system used in this guideline has been adapted from the Scottish Intercollegiate Guideline Network (2000).

A. Requires at least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendations. This grade may include systematic review and/or meta-analysis of randomized controlled trials.
B. Requires the availability of well conducted clinical studies, but no randomized clinical trials on the topic of the recommendation. This includes evidence from well-designed controlled studies without randomization, quasi-experimental studies, and non-experimental studies such as comparative studies, correlational studies, and case studies. The Registered Nurses Association of Ontario (RNAO) guideline development panel strongly supports the inclusion of well-designed qualitative studies in this category.
C. Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A draft guideline was submitted to a set of external stakeholders for review. The feedback received was reviewed and incorporated into the final draft guideline. This draft guideline was pilot implemented in selected practice settings in Ontario. Pilot implementation practice settings were identified through a "request for proposal" process conducted by the Registered Nurses Association of Ontario (RNAO). The implementation phase was evaluated, and the guideline was further refined and prepared for publication after the results of the evaluation were reported, and reviewed by the development panel.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC)*: In February 2007, the Registered Nurses Association of Ontario amended the current practice recommendations for this topic. Through the review process, no recommendations were deleted. However, several recommendations were combined, and a number were re-worded for clarity or to reflect new knowledge. These have been noted below as "changed" or "unchanged."*

Definitions for the grades of recommendation (Grades A-C) are repeated at the end of the Major Recommendations.

Practice Recommendations - PART A: Assessment

Screening for Pain

Recommendation 1 (Changed February 2007)

Screen all persons at risk for pain at least once a day (when undertaking other routine assessments) by asking the person or family/care provider about the presence of pain, ache or discomfort. In situations where the individual is non-verbal, use behavioural indicators to identify the presence of pain.

(Grade of Recommendation = C)

Parameters of Pain Assessment

Recommendation 2 (Unchanged)

Self-report is the primary source of assessment for verbal, cognitively intact persons. Family/care provider reports of pain are included for children and adults unable to give self-report.

(Grade of Recommendation = C)

Recommendation 3 (Changed February 2007)

A systematic, validated pain assessment tool is selected to assess the following basic parameters of pain:

- Location of pain
- Effect of pain on function and activities of daily living (i.e., work, interference with usual activities, etc.)
- Level of pain at rest and during activity
- Medication usage and adverse effects
- Provoking or precipitating factors
- Quality of pain (what words does the person use to describe pain? - aching, throbbing)

- Radiation of pain (does the pain extend from the site?)
- Severity of pain (intensity, 0-10 scale), pain related symptoms; and timing (occasional, intermittent, constant)

(Grade of Recommendation = C)

Recommendation 4 (Unchanged)

A standardized tool with established validity is used to assess the intensity of pain.

- Visual Analogue Scale (VAS)
- Numeric Rating Scale (NRS)
- Verbal Scale
- Faces Scale
- Behavioural Scale

(Grade of Recommendation = A)

Recommendation 5 (Changed February 2007)

Pain assessment in patient populations who are unable to give self-report (non-communicative), may include behavioural indicators using standardized measures and physiological indicators where appropriate.

(Grade of Recommendation = C)

Comprehensive Pain Assessment

Recommendation 6 (Changed February 2007)

The following parameters are part of a comprehensive pain assessment:

- Physical examination, relevant laboratory and diagnostic data
- Effect and understanding of current illness
- History of pain
- Meaning of pain and distress caused by the pain (current and previous)
- Coping responses to stress and pain
- Effects on activities of daily living
- Psychosocial and spiritual effects
- Psychological - social variables (anxiety, depression)
- Situational factors – culture, language, ethnic factors, economic effects of pain and treatment
- Person's preferences and expectations/beliefs/myths about pain management methods
- Person's preferences and response to receiving information related to his/her condition and pain

(Grade of Recommendation = C)

Reassessment and Ongoing Assessment of Pain

Recommendation 7 (Changed February 2007)

Pain is reassessed on a regular basis according to the type and intensity of pain and the treatment plan.

- Pain intensity and function (impact on activities) is reassessed at each new report of pain and new procedure, when intensity increases, and when pain is not relieved by previously effective strategies.
- Effectiveness of intervention (both pharmacological and non-pharmacological) is reassessed after the intervention has reached peak effect (e.g., for opioids: 15-30 minutes after parenteral opioid therapy; 1 hour after immediate release analgesic).
- 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.

(Grade of Recommendation = C)

Recommendation 8 (Changed February 2007)

The following parameters should be monitored on an ongoing basis in persistent pain situations:

- 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 scale)
- Barriers to implementing the treatment plan
- Effects of pain on activities of daily living (ADLs), sleep and mood
- Adverse effects of medications for pain treatment (e.g., nausea, constipation)
- Level of sedation
- Strategies used to relieve pain, both pharmacological and non-pharmacological

(Grade of Recommendation = C)

Recommendation 9 (Unchanged)

Unexpected intense pain, particularly if sudden or associated with altered vital signs such as hypotension, tachycardia, or fever, should be immediately evaluated.

(Grade of Recommendation = C)

Documentation of Pain Assessment

Recommendation 10 (Changed February 2007)

Document on a standardized form that captures the person's pain experience specific to the population and setting of care. Documentation tools will include:

- Initial assessment, comprehensive assessment and re-assessment

- Monitoring tools that track efficacy of intervention (0-10 scale)

(Grade of Recommendation = C)

Recommendation 11 (Unchanged)

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

(Grade of Recommendation = C)

Recommendation 12 (Unchanged)

Teach individuals 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.

(Grade of Recommendation = C)

Communicating Findings of a Pain Assessment

Recommendation 13 (Unchanged)

Validate with persons/care providers that the findings of the pain assessment (health care provider's and person's/care provider's) reflect the individual's experience of pain.

(Grade of Recommendation = C)

Recommendation 14 (Changed February 2007)

Communicate to members of the interdisciplinary team pain assessment findings by describing parameters of pain obtained through the use of a structured assessment tool, the relief or lack of relief obtained from treatment methods and related adverse effects, person's goals for pain treatment and the effect of pain on the person.

(Grade of Recommendation = C)

Recommendation 15 (Unchanged)

Advocate on behalf of the person for changes to the treatment plan if pain is not being relieved. The nurse will engage in discussion with the interdisciplinary health care team regarding identified need for change in the treatment plan. The nurse supports his/her recommendations with appropriate evidence, providing a clear rationale for the need for change, including:

- Intensity of pain using a validated scale
- Change in severity 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
- Person's goals for pain relief
- Effect of unrelieved pain on the person
- Absence/presence of adverse effects or toxicity
- Suggestions for specific changes to the treatment plan that are supported by evidence

(Grade of Recommendation = C)

Recommendation 16 (Unchanged)

Provide instruction to the person/care provider on:

- The use of a pain log or diary (provide a tool)
- Communicating unrelieved pain to the appropriate clinician and supporting them in advocating on their own behalf

(Grade of Recommendation = C)

Recommendation 17 (Unchanged)

Report situations of unrelieved pain as an ethical responsibility using all appropriate channels of communication in the organization, including individual/care provider documentation.

(Grade of Recommendation = C)

Recommendation 18 (Changed February 2007)

Refer persons with persistent pain whose pain is not relieved after following standard principles of pain management to:

- A clinical team member skilled in dealing with the particular type of pain
- A multidisciplinary team to address the complex emotional, psycho/social, spiritual and concomitant medical factors involved

(Grade of Recommendation = C)

Practice Recommendations - PART B: Management

Establishing a Plan for Pain Management

Recommendation 19 (Unchanged)

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

- Assessment findings
- Baseline characteristics of pain
- Physical, psychological, and sociocultural factors shaping the experience of pain
- Etiology
- Most effective pharmacological and non-pharmacological strategies
- Management interventions
- Current and future primary treatment plans

(Grade of Recommendation = C)

Recommendation 20 (Unchanged)

Provide individuals and families/care providers with a written copy of the treatment plan to promote their decision-making and active involvement in the management of pain. The plan will be adjusted according to the results of assessment and reassessment. Changes to the treatment plan will be documented and communicated to everyone involved in the implementation of the plan.

(Grade of Recommendation = A)

Pharmacological Management of Pain: Selecting Appropriate Analgesics

Please Note: The recommendations in this section have been reordered since the original guideline to reflect more closely the process of care. Advocating for referral (now Recommendation 29) is appropriate after all other aspects of analgesic selection have been considered.

Recommendation 21 (Changed February 2007)

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

- The type of pain (acute, persistent, nociceptive and/or neuropathic)
- Intensity of pain
- Potential for analgesic toxicity (age, renal impairment, peptic ulcer disease, thrombocytopenia)
- General condition of the person
- Concurrent medical conditions
- Response to prior or present medications
- Cost to the person and family
- The setting of care

(Grade of Recommendation = A)

Recommendation 22 (Changed February 2007)

Advocate for use of the most effective analgesic dosage schedules and least invasive pain management modalities:

- Tailor the route to the individual pain requirements and the care setting.

- The oral route is the preferred route for persistent pain and for acute pain as healing occurs.
- Intravenous administration is the parenteral route of choice after major surgery, usually via bolus and continuous infusion.
- Consider using a butterfly injection system to administer intermittent subcutaneous analgesics.
- Regional analgesia provides site-specific relief and is an effective pain management modality in certain populations and should be considered.

(Grade of Recommendation = C)

- The intramuscular route is not recommended because it is painful and not reliable.

(Grade of Recommendation = B)

- Epidural patient controlled analgesia is more effective than intravenous patient controlled analgesia in certain surgical procedures and should be considered for eligible patients.

(Grade of Recommendation = A)

Recommendation 23 (Changed February 2007)

Use a step-wise approach in making recommendations for the selection of analgesics for pharmacological management to match the intensity of pain unless contraindicated due to age, renal impairment or other issues related to the drug:

- Mild to moderate pain should be treated with acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs) unless the person has a history of ulcers or a bleeding disorder.
- Moderate to severe pain should be treated initially with an opioid analgesic, taking into consideration previous opioid use and adverse effects.

(Grade of Recommendation = B)

Recommendation 24 (Changed February 2007)

Recognize that a multi-modal analgesic approach is most effective for the treatment of pain and includes the use of adjuvant medications as part of treatment for mild pain and for specific types of pain, unless contraindicated.

- Adjuvant medications such as anticonvulsants, NSAIDs and anti-depressants are important adjuncts as they provide independent analgesia for specific types of pain, such as neuropathic pain.
- Caution is needed in administering adjuvant medications in the elderly who may experience significant anticholinergic and sedative adverse effects.

(Grade of Recommendation = A)

Recommendation 25 (Unchanged)

Consider the following pharmacological principles in the use of opioids for the treatment of severe pain:

- Mixed agonist-antagonists (e.g., pentazocine) are not administered with opioids because the combination may precipitate a withdrawal syndrome and increase pain.
- The elderly generally receive greater peak and longer duration of action from analgesics than younger individuals, thus dosing should be initiated at lower doses and increased more slowly ("careful titration").
- Special precautions are needed in the use of opioids with neonates and infants under the age of six months. Drug doses, including those for local anaesthetics, should be calculated carefully based on the current or most appropriate weight of the neonate. Initial doses should not exceed maximum recommended amounts.

(Grade of Recommendation = B)

Recommendation 26 (Changed February 2007)

Recognize that meperidine is not recommended for the treatment of pain.

- Meperidine is contraindicated in persistent pain due to the build-up of the toxic metabolite normeperidine, which can cause seizures and dysphoria. Meperidine toxicity is not reversible by naloxone.
- Meperidine has limited use in acute pain due to a lack of drug efficacy and a build-up of toxic metabolites, which could occur within 72 hours.

(Grade of Recommendation = A)

Recommendation 27 (Unchanged)

Advocate for consultation with a pain management expert for complex pain situations which include, but are not limited to:

- Pain unresponsive to standard treatment
- Multiple sources of pain
- Mix of neuropathic and nociceptive pain
- History of substance abuse

(Grade of Recommendation = C)

Pharmacological Management of Pain: Optimizing Pain Relief with Opioids

Recommendation 28 (Unchanged)

Ensure that the timing of analgesics is appropriate according to personal characteristics of the individual, pharmacology (i.e., duration of action, peak-effect and half-life) and route of the drug.

(Grade of Recommendation = B)

Recommendation 29 (Unchanged)

Recognize that opioids should be administered on a regular time schedule according to the duration of action and depending on the expectation regarding the duration of severe 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 an "as needed" basis.
- In persistent cancer pain, opioids are administered on an "around-the-clock" basis, according to their duration of action.
- Long-acting opioids are more appropriate when dose requirements are stable.

(Grade of Recommendation = A)

Recommendation 30 (Unchanged)

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:

- Cause of the pain
- Individual's response to therapy
- Clinical condition
- Concomitant drug use
- Onset and peak effect
- Duration of the analgesic effect
- Age
- Known pharmacokinetics and pharmacodynamics of the drugs administered. Doses are usually increased every 24 hours for persons with persistent pain on immediate release preparations, and every 48 hours for persons on controlled release opioids. The exception to this is transdermal fentanyl, which can be adjusted every 3 days.

(Grade of Recommendation = B)

Recommendation 31 (Changed February 2007)

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 individual's respiratory rate, and the type of surgery, and are usually administered as bolus medications through PCA pumps or epidural route.
- Breakthrough doses of analgesic should be administered to the person on an "as needed" basis according to the peak effect of the drug (po/pr = q1h; subcutaneous (SC) = q 30 min; intravenous (IV) = q 10-15 min).
- It is most effective to use the same opioid for breakthrough pain as that being given for "around-the-clock" dosing.
- Individuals with persistent pain should have:

- An immediate release opioid available for pain (breakthrough pain) that occurs between the regular administration times of the "around the-clock" medication.
- Breakthrough doses of analgesic for continuous cancer pain should be calculated as 10 to 15 percent of the total 24-hour dose of the routine "around-the-clock" analgesic.
- Breakthrough analgesic doses should be adjusted when the regular "around-the-clock" medication is increased.
- Adjustment to the "around-the-clock" dose is necessary if more than 2 to 3 doses of breakthrough analgesic are required in a 24-hour period, and pain is not controlled.

(Grade of Recommendation = C)

Recommendation 32 (Changed February 2007)

Use an equianalgesic table to ensure equivalency between analgesics when switching analgesics. Recognize that the safest method when switching from one analgesic to another is to reduce the dose of the new analgesic by 25–50% in a stable pain situation.

(Grade of Recommendation = C)

Recommendation 33 (Changed February 2007)

Ensure that alternate routes of administration are prescribed when medications cannot be taken orally, or if refractory nausea and vomiting, taking into consideration the most efficacious and least invasive route, individual preferences, care setting, cost and resources.

- Transdermal preparations for persons with persistent pain.
- Continuous subcutaneous opioid infusions for persistent cancer pain.

(Grade of Recommendation = A

Recommendation 34 (Unchanged)

Recognize the difference between drug addiction, tolerance and dependency to prevent these from becoming barriers to optimal pain relief.

(Grade of Recommendation = A)

Monitoring for Safety and Efficacy

Recommendation 35 (Changed February 2007)

Monitor persons taking opioids, recognizing that opioids used for people not in pain, or in doses larger than necessary to control the pain, or when they have not been titrated appropriately, can slow or stop breathing.

(Grade of Recommendation = A)

Recommendation 36 (Changed February 2007)

Monitor persons taking opioids for potential toxicity when the person exhibits:

- Unacceptable adverse effects such as, but not limited to, myoclonus, confusion, delirium refractory to prophylactic treatment
- In the presence of inadequate pain relief following appropriate dose titration.

Advocate for a change in treatment plan, as required.

(Grade of Recommendation = C)

Recommendation 37 (Changed February 2007)

Evaluate the efficacy of pain relief with analgesics at regular intervals and following a change in dose, route or timing of administration. Recommend changes in analgesics when inadequate pain relief is observed.

(Grade of Recommendation = C)

Recommendation 38 (Changed February 2007)

Refer to a pain specialist for individuals who require increasing doses of opioids that are ineffective in controlling pain. Evaluation should include assessment for residual pathology and other pain causes, such as neuropathic pain.

(Grade of Recommendation = C)

Anticipate and Prevent Common Adverse Effects of Opioids

Recommendation 39 (Changed February 2007)

Anticipate and monitor individuals taking opioids for common adverse effects such as nausea and vomiting, constipation and drowsiness, and institute prophylactic treatment as appropriate.

(Grade of Recommendation = A)

Recommendation 40 (Unchanged)

Counsel patients that adverse effects to opioids can be controlled to ensure adherence with the medication regime.

(Grade of Recommendation = C)

Recommendation 41 (Unchanged)

Recognize and treat all potential causes of adverse effects taking into consideration medications that potentiate opioid adverse effects:

- Sedation – sedatives, tranquilizers, antiemetics
- Postural hypotension – antihypertensives, tricyclics
- Confusion – phenothiazines, tricyclics, antihistamines and other anticholinergics

(Grade of Recommendation = A)

Anticipate and Prevent Common Adverse Effects of Opioids – Nausea and Vomiting

Recommendation 42 (Changed February 2007)

Assess all persons taking opioids for the presence of nausea and/or vomiting, paying particular attention to the relationship of the symptom to the timing of analgesic administration. Ensure that these persons are prescribed an antiemetic for use on an "as needed" basis with routine administration if nausea/vomiting persists.

(Grade of Recommendation = C)

Recommendation 43 (Unchanged)

Recognize that antiemetics have different mechanisms of action and selection of the right antiemetic is based on this understanding and etiology of the symptom.

(Grade of Recommendation = C)

Recommendation 44 (Unchanged)

Assess the effect of the antiemetic on a regular basis to determine relief of nausea/vomiting and advocate for further evaluation if the symptom persists in spite of adequate treatment.

(Grade of Recommendation = C)

Recommendation 45 (Unchanged)

Consult with prescribing clinician regarding switching to a different antiemetic if nausea/vomiting is determined to be related to the opioid, and does not improve with adequate doses of antiemetic.

(Grade of Recommendation = C)

Anticipate and Prevent Common Adverse Effects of Opioids – Constipation

Recommendation 46 (Changed February 2007)

Institute prophylactic measures for the treatment of constipation unless contraindicated, and monitor constantly for this adverse-effect.

- Laxatives should be prescribed and increased as needed to achieve the desired effect as a preventative measure for individuals receiving routine administration of opioids.

(Grade of Recommendation = B)

- Osmotic laxatives soften stool and promote peristalsis and may be an effective alternative for individuals who find it difficult to manage an increasing volume of pills.

(Grade of Recommendation = B)

- Stimulant laxatives may be contraindicated if there is impaction of stool. Enemas and suppositories may be needed to clear the impaction before resuming oral stimulants.

(Grade of Recommendation = C)

- Bulk forming agents should be avoided when bowel motility is compromised, for example, with opioids.

(Grade of Recommendation = C)

Recommendation 47 (Unchanged)

Counsel individuals on dietary adjustments that enhance bowel peristalsis recognizing personal circumstances (seriously ill individuals may not tolerate) and preferences.

(Grade of Recommendation = C)

Recommendation 48 (Changed February 2007)

Urgently refer persons with refractory constipation accompanied by abdominal pain and/or vomiting to the appropriate clinician.

(Grade of Recommendation = C)

Recommendation 49 (Unchanged)

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.

(Grade of Recommendation = C)

Anticipate and Prevent Common Adverse Effects of Opioids – Drowsiness/Sedation

Recommendation 50 (Changed February 2007)

Notify the appropriate clinician of confusion or hallucinations in order to evaluate drowsiness which continues beyond 72 hours, to determine the underlying cause.

(Grade of Recommendation = C)

Anticipate and Prevent Procedural Pain

Recommendation 51 (Changed February 2007)

Anticipate pain that may occur during procedures (e.g., medical tests, dressing changes, chest tube removal, line insertion/removal, etc.)

- Combine pharmacologic (e.g., topical anaesthetic) with non-pharmacologic options for prevention.
- Anticipate and prevent pain when performing procedures on infants to prevent sensitization for pain in the future.

(Grade of Recommendation = A)

Recommendation 52 (Unchanged)

Recognize that analgesics and/or local anaesthetics are the foundation for pharmacological management of painful procedures. Anxiolytics and sedatives are specifically for the reduction of associated anxiety. If used alone, anxiolytics and sedatives blunt behavioural responses without relieving pain.

(Grade of Recommendation = C)

Recommendation 53 (Changed February 2007)

Ensure that skilled supervision and appropriate monitoring procedures are instituted when moderate sedation is used.

(Grade of Recommendation = C)

Patient and Family Education

Recommendation 54 (Changed February 2007)

Provide the person and their family/care providers with information about their pain and the measures used to treat it, using an individualized approach, with particular attention focused on strategies for the prevention and treatment of adverse effects, and the correction of myths.

(Grade of Recommendation = A)

Recommendation 55 (Unchanged)

Ensure that individuals understand the importance of promptly reporting unrelieved pain, changes in their pain, new sources or types of pain and adverse effects from analgesics.

(Grade of Recommendation = C)

Recommendation 56 (Changed February 2007)

Clarify the differences between addiction, tolerance, and physical dependence to alleviate misbeliefs that can prevent optimal use of pharmacological methods for pain management.

- Addiction is a psychological dependence and is rare with persons taking opioids for persistent pain.
- Persons using opioids on a long-term basis for pain control may be on the same dose for years, but may require upward adjustments of dosage with signs of tolerance. Tolerance is usually not a problem and people can be on the same dose for years.
- Persons who no longer need an opioid after long-term use need to reduce their dose slowly over several weeks to prevent withdrawal symptoms because of physical dependence.

(Grade of Recommendation = A)

Effective Documentation

Recommendation 57 (Unchanged)

Document all pharmacological interventions on a systematic pain record that clearly identifies the effect of analgesic on pain relief. Utilize this record to communicate with interdisciplinary colleagues in the titration of analgesic. The date, time, severity, location and type of pain should all be documented.

(Grade of Recommendation = C)

Recommendation 58 (Unchanged)

Provide the individual and family in the home setting with a simple strategy for documenting the effect of analgesics.

(Grade of Recommendation = C)

Non-Pharmacological Management of Pain

Recommendation 59 (Changed February 2007)

Combine pharmacological methods with non-pharmacological methods to achieve effective pain management.

- 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
    - Pressure/vibration
    - Music

(Grade of Recommendation = A)

Recommendation 60 (Changed February 2007)

Implement educational and psychosocial interventions that facilitate coping of the individual and family early in the course of treatment.

(Grade of Recommendation = A)

Recommendation 61 (Changed February 2007)

Institute educational and psycho-educational interventions as part of the overall plan of treatment for pain management.

(Grade of Recommendation = A)

Recommendation 62 (Changed February 2007)

Recognize that cognitive-behavioural strategies combined with other approaches, including multidisciplinary rehabilitation, can be helpful strategies for treatment of persistent, non-malignant pain.

Grade of Recommendation = A)

Education Recommendations

Recommendation 63 (Changed February 2007)

Nurses prepared at the entry to practice level must have knowledge of the principles of pain assessment and management.

(Grade of Recommendation = C)

Recommendation 64 (Unchanged)

The principles of pain assessment and management should be included in orientation programs and be made available through professional development opportunities in the organization.

(Grade of Recommendation = C)

Recommendation 65 (Unchanged)

Educational programs should be designed to facilitate change in nurses´ knowledge, skills, attitudes and beliefs about pain assessment and management in order to support practice across populations and settings.

(Grade of Recommendation = C)

Recommendation 66 (Changed February 2007)

Educational programs must support translation of knowledge into practice, and must address the resources necessary to support practice (e.g., corporate standards, practice modifications, reminder systems, removal of barriers, etc.) across populations and settings.

(Grade of Recommendation = C)

Organization and Policy Recommendations

Recommendation 67 (Changed February 2007)

Nursing regulatory bodies should ensure that Standards of Nursing Practice include the adoption of standards for accountability for pain management.

(Grade of Recommendation = C)

Recommendation 68 (Unchanged)

Health care organizations must have documentation systems in place to support and reinforce standardized pain assessment and management approaches.

(Grade of Recommendation = C)

Recommendation 69 (Unchanged)

Health care organizations must have educational resources available to individuals and families/care providers regarding their participation in achieving adequate pain relief.

(Grade of Recommendation = C)

Recommendation 70 (Unchanged)

Health care organizations must demonstrate their commitment to recognizing pain as a priority problem. Policies must clearly support or direct expectations of staff that satisfactory pain relief is a priority.

(Grade of Recommendation = C)

Recommendation 71 (Unchanged)

Health care organizations must ensure that resources are available to individuals, family/care providers and staff to provide effective pain assessment and management, such as access to experts in pain management.

(Grade of Recommendation = C)

Recommendation 72 (Unchanged)

Health care organizations need to demonstrate support for an interdisciplinary approach to pain care.

(Grade of Recommendation = C)

Recommendation 73 (Unchanged)

Health care organizations must have quality improvement systems in place to monitor the quality of pain management across the continuum of care.

(Grade of Recommendation = C)

Recommendation 74 (Unchanged)

In planning educational strategies, consider the most effective methods for dissemination and implementation of guideline recommendations. These methods include, but are not limited to:

- The use of a model of behaviour change to guide the development of strategies for implementation
- The use of a combination of strategies to influence practice change
- Designing implementation strategies that take into consideration the influence of the organizational environment

(Grade of Recommendation = A)

Recommendation 75 (Unchanged)

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process
- Dedication of a qualified individual to provide the support needed for the education and implementation process
- Ongoing opportunities for discussion and education to reinforce the importance of best practices

- Opportunities for reflection on personal and organizational experience in implementing guidelines

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of clinical practice guidelines* based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline "Assessment and Management of Pain."

(Grade of Recommendation = C)

Definitions:

Grades of Recommendations

A. Requires at least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendations. This grade may include systematic review and/or meta-analysis of randomized controlled trials.
B. Requires the availability of well conducted clinical studies, but no randomized clinical trials on the topic of the recommendation. This includes evidence from well-designed controlled studies without randomization, quasi-experimental studies, and non-experimental studies such as comparative studies, correlational studies, and case studies. The Registered Nurses Association of Ontario (RNAO) guideline development panel strongly supports the inclusion of well-designed qualitative studies in this category.
C. Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate assessment and management of pain

POTENTIAL HARMS

Side Effects and Toxicities of Medications Used to Manage Pain

- Opioids:
    - Common side effects of opioids include nausea and vomiting, constipation and drowsiness.
    - Toxicity of opioids may include, but not be limited to, myoclonus, confusion, delirium refractory to prophylactic treatment.
    - Mixed agonist-antagonists (e.g., pentazocine) are not administered with opioids because the combination may precipitate a withdrawal syndrome and increase pain.
    - The elderly generally receive greater peak and longer duration of action from analgesics than younger individuals, thus dosing should be initiated at lower doses and increased more slowly ("careful titration").
    - Special precautions are needed in the use of opioids with neonates and infants under the age of six months. Drug doses, including those for local anaesthetics, should be calculated carefully based on the current or most appropriate weight of the neonate. Initial doses should not exceed maximum recommended amounts.
- Caution is needed in administering adjuvant medications (such as anticonvulsants, non-steroidal anti-inflammatory drugs [NSAIDS] and anti-depressants) in the elderly who may experience significant anticholinergic and sedative adverse effects.

CONTRAINDICATIONS

CONTRAINDICATIONS

Stimulant laxatives may be contraindicated if there is impaction of stool.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Nurses working in specialty areas such as pediatrics, gerontology, chronic non-malignant pain, malignant pain, acute trauma and surgical areas will require further practice direction from clinical practice guidelines in their unique area of focus.
- These best practice guidelines are related only to nursing practice and not intended to take into account fiscal efficiencies. These guidelines are not binding for nurses and their use should be flexible to accommodate client/family wishes and local circumstances. They neither constitute a liability nor discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor Registered Nurses Association of Ontario (RNAO) give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work. Any reference throughout the document to specific pharmaceutical products as examples does not imply endorsement of any of these products.
- The guideline contains recommendations for best nursing practices in the assessment and management of pain for Registered Nurses (RNs) and Registered Practical Nurses (RPNs). It is acknowledged that the individual competency of nurses varies between nurses and across categories of nursing

professionals (RNs and RPNs) and is based on knowledge, skills, attitudes, critical analysis and decision making which is enhanced over time by experience and education. It is anticipated that individual nurses will perform only those aspects of pain assessment and management for which they have received appropriate education and experience, and which are within the scope of their practice.

- It is expected that nurses, both registered nurses (RNs) and registered practical nurses (RPNs), will seek appropriate consultation in instances where the patient´s care needs surpass the ability of the individual nurse to act independently. It is acknowledged that effective patient care depends on a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and patients, ever mindful of the personal preferences and unique needs of each individual patient.
- The February 2007 supplement to the nursing best practice guideline Assessment and Management of Pain is the result of a three year scheduled revision of the guideline. Additional material has been integrated in an attempt to provide the reader with current evidence to support practice. Similar to the original guideline publication, this document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. This supplement should be used in conjunction with the guideline as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

November 2002 Guideline

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation. In this regard, Registered Nurses Association of Ontario (RNAO) (through a panel of nurses, researchers and administrators) has developed the *Toolkit: Implementation of Clinical Practice Guidelines*, based on available evidence, theoretical perspectives and consensus. The "Toolkit" is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

The "Toolkit" provides step by step directions to individuals and groups involved in planning, coordinating, and facilitating the guideline implementation. Specifically, the "Toolkit" addresses the following key steps:

1. Identifying a well-developed, evidence-based clinical practice guideline
2. Identification, assessment and engagement of stakeholders
3. Assessment of environmental readiness for guideline implementation
4. Identifying and planning evidence-based implementation strategies
5. Planning and implementing evaluation
6. Identifying and securing required resources for implementation

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The "Toolkit" is one key resource for managing this process.

February 2007 Supplement

The Registered Nurses' Association of Ontario and the guideline panel have compiled a list of implementation strategies to assist health care organizations or health care disciplines who are interested in implementing this guideline. A summary of these strategies follows:

- Have at least one dedicated person such as an advanced practice nurse or a clinical resource nurse who will provide support, clinical expertise and leadership. The individual should have good interpersonal, facilitation and project management skills.
- Conduct an organizational needs assessment related to the care of adults with asthma to identify current knowledge and further educational requirements.
- Create a vision to help direct the change effort and develop strategies for achieving and sustaining the vision.
- Establish a steering committee comprised of key stakeholders and interdisciplinary members committed to leading the change initiative. Identify short term and long-term goals.
- Identify and support designated best practice champions on each unit to promote and support implementation. Celebrate milestones and achievements, acknowledging work well done.
- Provide organizational support such as having the structures in place to facilitate best practices in asthma care. For example, having an organizational philosophy that reflects the value of best practices through policies and procedures. Develop new assessment and documentation tools.
- Pain initiatives within organizations should leverage on the standards of the Canadian Pain Society (CPS) and the Canadian Council of Health Services Accreditation (CCHSA) in order to support implementation and sustainability of practice change.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Slide Presentation
Staff Training/Competency Material
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Registered Nurses Association of Ontario (RNAO). Assessment and management of pain. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2002 Nov. 142 p. [109 references]

Registered Nurses Association of Ontario (RNAO). Assessment and management of pain: supplement. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007 Feb. 27 p. [63 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Nov (addendum released 2007 Feb)

GUIDELINE DEVELOPER(S)

Registered Nurses Association of Ontario - Professional Association

SOURCE(S) OF FUNDING

Funding was provided by the Ontario Ministry of Health and Long Term Care.

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Not stated

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Registered Nurses Association of Ontario (RNAO) received funding from the Ministry of Health and Long-Term Care (MOHLTC). This guideline was developed by a panel of nurses and researchers convened by the RNAO and conducting its work independent of any bias or influence from the MOHLTC.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

November 2002 Guideline

Electronic copies: Available in Portable Document Format (PDF) in English and French from the Registered Nurses Association of Ontario (RNAO) Web site.

March 2006 Supplement

Electronic copies: Available in Portable Document Format (PDF) from the RNAO Web site.

Print copies: Available from the Registered Nurses Association of Ontario (RNAO), Nursing Best Practice Guidelines Program, 158 Pearl Street, Toronto, Ontario M5H 1L3.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Toolkit: implementation of clinical practice guidelines. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2002 Jan. 91 p. Available in English and French from the Registered Nurses Association of Ontario (RNAO) Web site.
- Assessment and management of pain in the elderly: self-directed learning package for nurses in long-term care. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007 May 36 p. Available from the RNAO Web site.
- Assessment and management of pain: workshop facilitator's guide. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007 April 12 p. Available from the RNAO Web site.
- Assessment and management of pain: workshop slides. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007 April. Available from the RNAO Web site.
- E-learning: assessment and management of pain. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2006. Available from the RNAO Web site.

Print copies: Available from the Registered Nurses Association of Ontario (RNAO), Nursing Best Practice Guidelines Program, 158 Pearl Street, Toronto, Ontario M5H 1L3.

PATIENT RESOURCES

The following is available:

- Health education fact sheet. Gaining control of your pain. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2003 Nov. 2 p.

Electronic copies: Available in Portable Document Format (PDF) in English and French from the Registered Nurses Association of Ontario (RNAO) Web site.

Print copies: Available from the Registered Nurses Association of Ontario (RNAO), Nursing Best Practice Guidelines Program, 158 Pearl Street, Toronto, Ontario M5H 1L3.

NGC STATUS

This NGC summary was completed by ECRI on December 17, 2003. The information was verified by the guideline developer on January 16, 2004. This summary was updated on May 3, 2005 following the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs). This NGC summary was updated by ECRI Institute on January 3, 2008. The updated information was verified by the guideline developer on March 4, 2008.

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