



Pain Assessment and Management Guideline -- SAHS

I. Purpose Statement:

- A. This Clinical Practice Guideline (CPG) for pain was written as a tool to enhance the practitioner's clinical skills by presenting therapeutic options with supporting information. It does not dictate one approach, but provides principles and guidance to effective, safe, and timely pain management. The ultimate decision regarding a particular course must be made by the individual clinician, in light of the patient's clinical presentation individual patient needs, and the available diagnostic and treatment options.

Patients' and support persons' misconceptions and lack of knowledge about pain management can be significant barriers to adequate pain relief. It is imperative that patients and support persons understand the importance of adequate pain management, with the ultimate goal of pain therapy focusing on improving overall tolerability and functionality. Pain management regimens should be multimodal whenever possible and include both pharmacological and non-pharmacological interventions.

The expected outcome of successful implementation of this guideline is to improve the healthcare experience, and to reduce the morbidity that is associated with unmanaged pain.

This guideline addresses adult patients and is primarily focused on management of acute pain due to inpatient procedures. Neonatal pain assessment and management is addressed in the Pain Assessment & Management of the Neonate in the NICU policy.

- B. This evidence based guideline has been developed by a formal interdisciplinary team to assist Licensed Independent Practitioners (LIP) in caring for patients. They are meant as a guide and not a substitute for clinical judgment.

II. Definitions:

A. Pain Definition

1. Pain is defined as an unpleasant sensory and emotional experience most often associated with actual or potential tissue damage, or described in terms of such damage.
2. Pain is not just the unpleasant sensation, not just the perception of the sensation, but also the emotional reaction to or experience of the perceived sensation.
3. Opioid tolerant (adult): those receiving, for one week or longer at least 60 mg oral morphine milligram equivalents.
4. Opioid: Drugs that bind to opioid receptors in the central nervous system. This can include both natural and synthetic compounds. Examples include: morphine, oxycodone, hydrocodone and fentanyl.
5. Narcotic: legal term to refer to drugs that derived naturally or per chemical synthesis from opium or coca leaves. Most often used when these drugs are seized for illegal use.

III. Equipment: None

IV. Procedure:

- A. To achieve the goal of improving the patient's outcome, this guideline addresses the following critical points:
1. Efficient and effective initial assessment
 2. Developing a collaborative pain management strategy that includes multimodal pain management and implementing non-pharmacological interventions whenever possible.
 3. Providing appropriate education for the patient and family regarding planned therapeutic interventions.
 - a. Side effects
 - b. Risks of prescribed medications
 - c. Realistic expectations of pain relief
 - d. Goals of pain relief
- B. Pain Assessment:
1. Pain is subjective which creates for the clinician the primary dilemma of pain management.
 2. A patient's report of pain should be believed unless and/or until there is overwhelming evidence to distrust the self-report
 3. It also imperative when assessing pain to objectively assess functionality and tolerability when a pain relief strategy has been implemented. It is important to communicate with patients about perceived improvement in functionality and tolerability and to document findings.
 4. Consider anxiety and depression as part of the pain assessment. These factors often influence patient's subjective perception of pain, and addressing these issues or referring for treatment promptly can often aid in keeping opioid doses to a minimum. Pain is also a risk factor for suicide.
- C. Pain Management Strategy
1. Utilize a multimodal pain management strategy for pain management. This consists of using two or more different methods (non-pharmacologic) or medications to manage pain rather than using opioids alone.
 2. See Appendix A for algorithms for recommended pain management strategies for both opioid naïve and opioid tolerant patients.
 3. See Appendix B for an equianalgesic chart
 - a. It is NOT intended for initial dosing
 - b. The purpose of this chart is to provide approximate equivalent doses of opioids in patients previously treated for moderate to severe pain. Consider the total dose received in the last 24hrs to convert
 - c. It is recommended to begin with a 25 – 50% lower dose than the calculated equianalgesic dose when changing medications to account for cross tolerance.
 4. See Appendix C for a morphine milligram equivalent chart.
 - a. The MME conversion factor is intended only for analytic purposes where prescription data are used to retrospectively calculate daily MME to perform analysis of potential risks associated with opioid prescribing
 - b. This is not intended for equianalgesic dosing for clinical application (see Appendix B)

5. A bowel protocol of a laxative and stool softener should be started at the time opioids are initiated unless contraindicated.
6. All PRN pain orders should be written with the indication for treatment. In the instance where multiple PRN pain orders are written, they MUST include an indication that differentiates to the nursing staff when to administer the different medications.
7. Use of intra-muscular (IM) route for pain management is discouraged in all patients when there is another route available. Due to variable absorption rates, pain relief is unpredictable with the IM route.
8. Meperidine use for pain is not recommended. Oral meperidine is non-formulary at Saint Alphonsus and intravenous is restricted to prevent and treat drug induced or blood product induced rigors, treatment of postoperative shivering or treatment of targeted temperature management-related shivering. Meperidine does not interfere with a hepatobiliary iminodiacetic acid scan (HIDA scan).
9. Fentanyl patches should not be utilized in opioid naïve patients and/or patients with acute pain.
10. Screen and consider increased monitoring and lower doses for patients who are at potential high risk for adverse effects of pain therapy medications:
 - (1) Sleep apnea
 - (2) Morbid obesity
 - (3) Elderly (age greater than 65)
 - (4) Concurrent central nervous system depressing agents
 - (5) Have a compromised level of consciousness
 - (6) Renal or hepatic impairment (contact pharmacy for specific adjustment information)
11. All patients receiving opioid therapy should be screened for risk for potential abuse/misuse of opioids by using an opioid risk assessment tool.
12. The Prescription Drug Monitoring Program (PDMP) should be used to check all patients initially receiving opioid therapy and with continued treatment.
13. If the primary service is having difficulty managing a patient's pain after suggested pain strategies are implemented, consider ordering an inpatient pain consult (Boise only) or contacting a pharmacist.
14. The discharge plan should provide the patient and support persons with a workable, effective and safe pain management program for use at home, foster continuity of pain management across the care continuum, and promote understanding of the treatment plan.
15. Early discharge planning ensures continuity of care and pain management. It is important to assess the discharge environment to evaluate support for the pain management plan proposed for discharge and address the patient's ability to adhere to treatment procedures. It is desirable that, if possible, the effectiveness of a plan of care is evaluated before discharge.
16. It is important that discharge teaching include anticipated needs and problems, including possible use of over-the-counter medications for pain relief.
17. Consider writing the diagnosis code on the discharge prescription to mitigate potential problems as retail pharmacies are now implementing different requirements on opioid prescriptions.
18. Limit opioid prescribing for acute pain to the minimum amount that is appropriate for the patient with a maximum of 7 days.

19. Patients should be given a clear strategy/tapering schedule to wean off opioids (or back to baseline daily dosing for patients on chronic opioid therapy). Suggested tapers below which may need to be adjusted based on patient tolerability.
 - a. Acute pain only: Rapid taper by eliminating at least one dose every day.
 - b. Acute on chronic pain: Rapid taper of acute pain regimen by eliminating at least one dose every day until back to baseline daily regimen
 20. For patients on chronic opioid therapy who wish to be tapered completely off of their opioids, a slower taper necessary to avoid withdrawal symptoms. Recommend that this is done by the primary physician managing the patient's pain. Suggested initial tapers below which may need to be adjusted based on patient tolerability.
 - (1) Taper (over weeks): Reduce by 10 – 20 % every week
 - (2) Taper (over months): Reduce by 10 – 20 % every 4 weeks
 21. Consider a naloxone prescription for patients receiving opioid therapy and especially for those deemed high risk for overdose.
- D. Pain Management Education
1. Education decreases emotional distress, enhances coping skills, and enables the patient to participate in treatment. Patients and family should be educated regarding:
 - a. Realistic pain management goals
 - b. Pain control mechanisms utilized and/or available (including non- pharmacologic alternatives)
 - c. The patient's role/responsibility in management of pain.
 - d. The potential limitations, side effects and adverse reactions that can occur with pain treatments.
 - e. Education regarding the risk potential for developing addiction should be provided to all patients receiving opioid therapy
 - f. Education should be adjusted to appropriately address patients that have a physiological condition, or limited intellectual capacity that would impair their ability to understand the instructions.

V. Related Policies/Forms:

- A. Appendix A: Pain Management Algorithms
- B. Appendix B: Equianalgesic Chart
- C. Appendix C: Morphine Milligram Equivalent (MME) Chart
- D. Patient Education:
 1. PE-121-003 Pain Management Relaxation, Distraction & Imagery to Help Control Pain
 2. PE-121-004 General Pain Education
- E. Policies:
 1. [Pain Assessment & Management of the Neonate -- NICU](#)

VI. References:

- A. Acute Pain Management Clinical Practice Guideline, U.S. Department of Health and Human Services, AHCPR
- B. Joint Commission New and Revised Standards Related to Pain Assessment and Management. Retrieved from: https://www.jointcommission.org/assets/1/18/Joint_Commission_Enhances_Pain_Assessment_and_Management_Requirements_for_Accredited_Hospitals1.PDF. Assessed: August, 2018.

- C. Pino, CA, et al. Prescription of opioids for acute pain in opioid naïve patients. Retrieved from https://www.uptodate.com/contents/prescription-of-opioids-for-acute-pain-in-opioid-naive-patients?search=acute%20pain%20management&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2. Last updated May, 2018. Accessed: August, 2018.
- D. Arnold RM, et al. Management of acute pain in the patient chronically using opioids. Retrieved from: https://www.uptodate.com/contents/management-of-acute-pain-in-the-patient-chronically-using-opioids?search=acute%20pain%20management&source=search_result&selectedTitle=3~150&usage_type=default&display_rank=3Last updated May, 2018. Accessed: August 2018.
- E. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain – Unites States 2016. *MMWR Recomm Rep* 2016;65(No.RR-1): 1 – 49.
- F. PL Detail-Document, Equianalgesic Dosing of Opioids for Pain Management. *Pharmacist's Letter/Prescriber's Letter*. August 2012.
- G. CDC. Analyzing Prescription Data and Morphine Milligram Equivalents (MME). Retrieved from <https://www.cdc.gov/drugoverdose/resources/data.html>. Accessed November, 2018.

VII. Approval Committee(s):

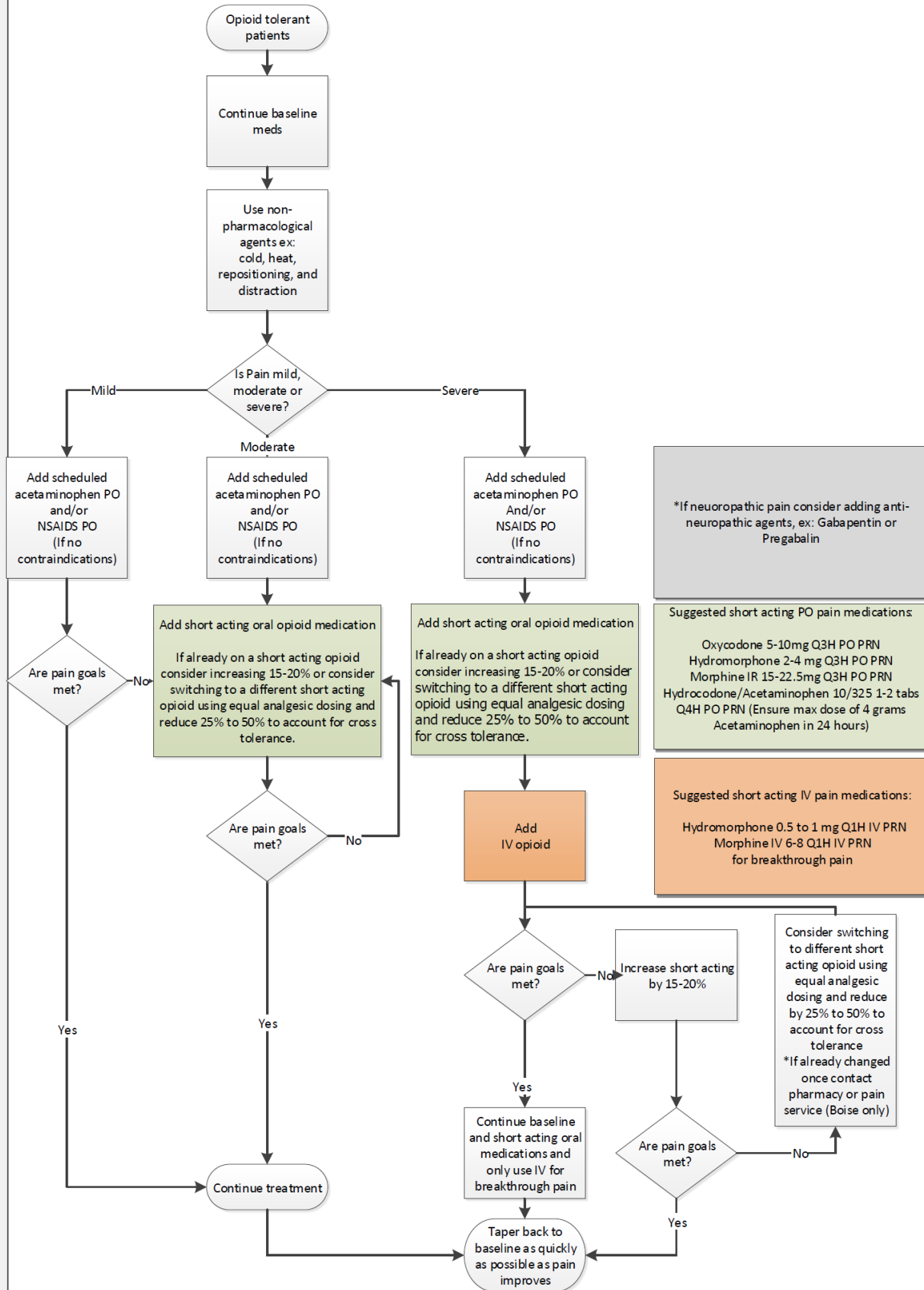
- A. SAHS Pharmacy and Therapeutics: 4/22/21
- B. Baker City MEC: 5/20/21
- C. Boise MEC: 5/24/21
- D. Nampa MEC: 5/4/21
- E. Ontario MEC: 5/18/21

Appendix A:

Pain services decision tree

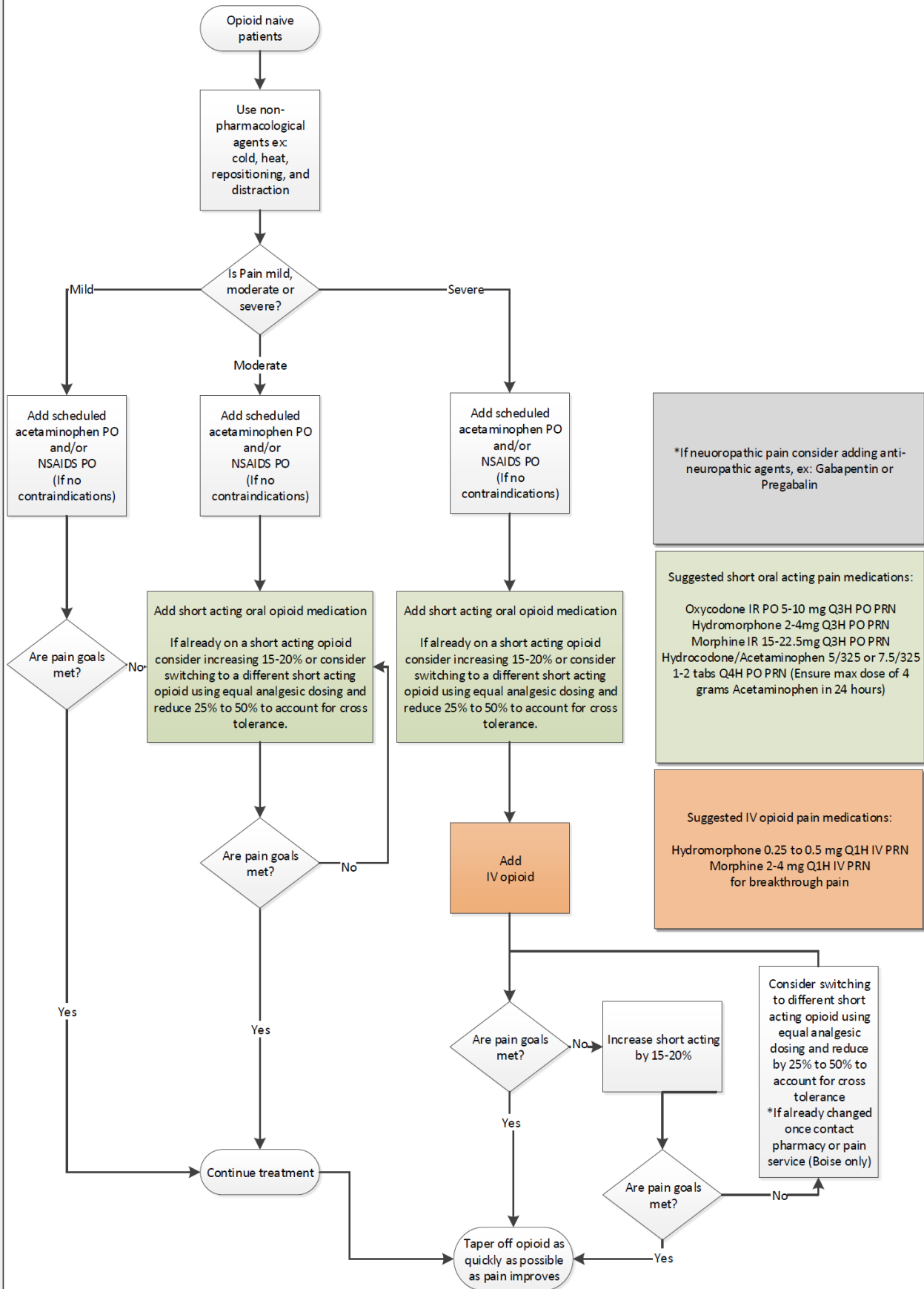
Opioid Tolerant

Receiving for one week or longer at least 60 mg oral morphine milligram equivalents/day



Pain services decision tree

Opioid Naive



Appendix B:

Equianalgesic Comparison Chart

The purpose of this chart is to provide approximate equivalent doses of opioids in patients previously treated for moderate to severe pain. Consider the total dose received in the last 24hrs to convert

THIS IS NOT INTENDED FOR INITIAL DOSING

IT IS RECOMMENDED TO BEGIN WITH A 25 – 50% LOWER DOSE THAN THE EQUIANALGESIC DOSE WHEN CHANGING MEDICATIONS TO ACCOUNT FOR CROSS TOLERANCE

Opioid	Parenteral (mg) IM, subcutaneous, IV	Oral (mg)
Morphine	10	30 (all oral formulations)
Hydrocodone	N/A	30
Hydromorphone	1.5	7.5 (all oral formulations)
Oxycodone	N/A	20 (all oral formulations)
Oxymorphone	1	10
Meperidine	75	300
Codeine Not recommended	100	200
Tapentadol	N/A	75
Tramadol	N/A	300
Methadone*	Contact Pain Service or Pharmacy for guidance	Contact Pharmacy or Pain Service for guidance
Fentanyl**	Contact Pain Service or Pharmacy for guidance	Contact Pain Service or Pharmacy for guidance
Buprenorphine	Contact Pain Service or Pharmacy for guidance	Contact Pain Service or Pharmacy for guidance

**The conversion ratio of methadone to the other opioids is highly variable and depends on numerous factors: patient tolerance, morphine dose, length of dosing, etc. Use caution when converting because toxicity can occur due to drug accumulation. Start with lower doses and titrate upward as needed based on patient response. Also, methadone has many significant inherent dangers and drug interactions – please review before initiation of therapy.*

***Fentanyl patches shouldn't be used for opioid naïve patients and/or patients with acute pain*

See next page for steps in calculating an equianalgesic dose

Calculating Equianalgesic Dose

Total 24 hr. dose (based on route) of **currently** administered opioid

Total 24 hr. dose (based on route) of **new** opioid

Equianalgesic dose (based on route) for **current** drug

=

Equianalgesic dose (based on route) for **new** opioid

Example: A patient used approximately 30 mg of IV morphine via a PCA over the past 24 hr. Convert to PO oxycodone.

$$\frac{30 \text{ mg IV morphine (current 24 hr dose)}}{10 \text{ mg IV (current equianalgesic dose)}} = \frac{X \text{ mg PO oxycodone}}{20 \text{ mg PO (new equianalgesic dose)}}$$

X = 60 mg PO oxycodone/24 hours

Consider dose reduction of 25 to 50% to account for cross tolerance = 45 to 30 mg PO oxycodone/24 hours

Dose and duration dependent on patient needs and available dosage forms

Appendix C:

Morphine Milligram Equivalent (MME) Chart

The MME conversion factor is intended only for analytic purposes where prescription data are used to retrospectively calculate daily MME to perform analysis of potential risks associated with opioid prescribing

THIS IS NOT INTENDED FOR EQUIANALGESIC DOSING FOR CLINICAL APPLICATION – SEE APPENDIX B

Opioid	Oral MME Conversion Factor*
Morphine	1
Hydrocodone	1
Hydromorphone	4
Oxycodone	1.5
Tramadol	0.1
Oxymorphone	3
Meperidine	0.1
Codeine	0.15
Methadone	3
Tapentadol	0.4
Fentanyl, buccal/SL tablet or lozenge/troche (mcg)	0.13
Fentanyl, film or oral spray (mcg)	0.18
Fentanyl, nasal spray (mcg)	0.16
Fentanyl, transdermal patch (mcg/hr)*	7.2
Buprenorphine**	N/A

** A special adjustment was made to permit use of the above conversion factor with fentanyl patches to account for the fact that such patches are described in units of mcg/hour and are used for more than one day.*

Example 25 mcg/hr fentanyl patch x 24 hours = 600 mcg/day fentanyl = 60 mg/day oral MME, with the conversion factor not accounting for days of use would be 60/25 = 2.4

However, since the fentanyl patch remains in place for 3 days, the conversion factor is multiplied by 3 (2.4 x 3 = 7.2)

Example: 25 mcg/hr fentanyl patch x (10 patches/30 days) x 7.2 = 60 MME/day

**** Buprenorphine products do not have an associated MME conversion factor. Buprenorphine products are partial opioid agonists prescribed for pain and as part of medication assisted treatment for opioid use disorder.**

Buprenorphine doses are not expected to be associated with overdose risk in the same dose dependent manner as doses for full agonist opioids