

PROTOCOL FOR: Pain & Comfort Management: Perioperative Care - DRAFT

- POLICY:**
1. All ambulatory and admit day of surgery patients will be educated about pain intensity scale 0-10. If the patient cannot use the numeric scale, the the FLACC scale will be used to assess pain level.
 2. All ambulatory and admit day of surgery patients will be assessed prior to procedures for acute and chronic pain, and this will be documented in the medical record.
 3. Preoperatively, patients will be encouraged to establish realistic and achievable pain relief/comfort goals (e.g., a pain rating of less than 4 (scale 0 - 10) to make it easy to cough, deep breathe, and turn upon discharge).
 4. Hemodynamic stability will be maintained during management of pain.

DESIRED PATIENT

- OUTCOMES:**
1. Patient states understanding of pain intensity scale and pain relief/comfort goals prior to the procedure.
 2. Patient will establish a realistic and achievable goal for pain relief/comfort prior to the procedure.
 3. Patient verbalizes understanding of importance of using non-pharmacological methods of alleviating pain and discomfort (e.g., cold therapy, relaxation breathing, and music).
 4. Patient maintains hemodynamic stability including respiratory/cardiac status and appropriate/expected level of consciousness.
 5. Patient describes effective use of at least one non-pharmacological method of managing pain, when capable (e.g., elevating operative limb, splinting/deep breathing).
 6. Patient shows effective use of PCA/PCEA as indicated and discusses expected results of regional techniques.
 7. Patient verbalizes evidence of receding pain level and increased comfort with pharmacological and non-pharmacological interventions.
 8. Patient states acceptable level of pain and comfort with movement or activity at time of transfer or discharge home.
 9. The ambulatory patient verbalizes understanding of discharge instruction plans:
 - a. specific drug to be taken
 - b. frequency of drug administration
 - c. potential side effects of medication
 - d. potential drug interactions, *per medication reconciliation sheet*
 - e. specific precaution to follow when taking medication (e.g., physical limitations, dietary restrictions)

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- f. name and telephone number of the physician/resource to notify about pain, problems, and other concerns.
- 10. The ambulatory patient states understanding or demonstrates effective use of non-pharmacological methods of pain control (e.g., cold/heat therapy, relaxation breathing, imagery, music).
- 11. The ambulatory patient states achievement of pain/comfort treatment goals and level of satisfaction with pain relief and comfort management in the PACU setting.

**CLINICAL
ASSESSMENT AND
CARE:**

- 1. Preoperative -
 - a. review vital signs data and patient history
 - b. educate patient about methods for rating pain
 - c. assess for acute and chronic pain, per department protocol
 - d. observe for pain behaviors or expressions, such as grimacing, frowning, crying, restlessness
 - e. review analgesic history (opioid, non-opioid, and adjuvant analgesics), for dose, frequency, effectiveness, adverse effects, and other medications that may influence choice of analgesics (e.g., anticoagulant, antihypertensive, muscle relaxants).
 - f. assess for patient preferences, acceptable levels of pain/comfort, educational needs, cultural preferences or personal beliefs that may result in restrictions, and pertinent lab results.
- 2. Intraoperative -
 - a. during sedation procedures, assess pain immediately before and after procedure; assess for sedation level and comfort per hospital policy on moderate sedation
 - b. during local topical/infiltration procedures, assess pain immediately before and after procedure, and per unit protocol
 - c. report inadequate pain relief to physician
- 3. Postoperative -
 - a. monitor vital signs per structure standards or per order
 - b. assess pain and comfort levels on admission and until transfer to receiving unit or discharge to home; reassess frequently until pain or discomfort is controlled
 - c. administer medications per order; notify physician or LIP for inadequate management or when need to exceed maximum dose is reached

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- d. identify patient correctly, validate orders, implement correct name of drug, dose, amount, route, and time.
- e. initiate or adjust IV and regional infusions as indicated and ordered, based on hemodynamic status.
- f. use non-pharmacologic interventions to complement, not replace, pharmacological interventions
- g. administer comfort measures as needed, including
 - 1) Physical/physiological (positioning, pillow, heat/cold therapies, sensory aids)
 - 2) Sociocultural (family / care giver, interpreter visit)
 - 3) Psycho-spiritual (chaplain, religious objects)
 - 4) Environmental (confidentiality, privacy)
- h. address nausea with pharmacological interventions or other techniques and discuss expectations
- i. educate ambulatory patient and family/caregiver:
 - 1) Pain and comfort measures
 - 2) Untoward symptoms to observe
 - 3) Regional or local anesthetic effects dissipating after discharge (numbness, motor weakness, or inadequate relief and potential adjustments).
 - 4) Availability of resources, if needed

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 7/09

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