

Title: Pain Management		
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<p>Discrete Operating Unit/Facility: Banner Baywood Medical Center Banner Behavioral Health Hospital Banner Boswell Medical Center Banner Casa Grande Medical Center Banner Churchill Community Hospital Banner Del E Webb Medical Center Banner Desert Medical Center Banner Estrella Medical Center Banner Fort Collins Medical Center Banner Gateway Medical Center Banner Goldfield Medical Center Banner Heart Hospital Banner Ironwood Medical Center Banner Lassen Medical Center Banner Ocotillo Medical Center Banner Payson Medical Center Banner Thunderbird Medical Center Banner--University Medical Center Phoenix Banner--University Medical Center South Banner--University Medical Center Tucson East Morgan County Hospital McKee Medical Center North Colorado Medical Center Ogallala Community Hospital Page Hospital Platte County Memorial Hospital Sterling Regional Medical Center Torrington Community Hospital Washakie Medical Center Wyoming Medical Center</p>		

Introduction

Purpose / Population

1. **Purpose:** Patient reports or exhibits behaviors that indicate a safe and acceptable level of comfort.
 2. **Population:** Adult, Pediatric, and Neonatal Patients in Acute Care Settings, excluding Hospice or Palliative Care Patients
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Definitions

Anticipatory pain: anticipated nociceptive event (procedures, therapies)

Child Life Specialist: Trained professionals with expertise in helping children and their families cope with hospitalization through play, preparation, education, and self-expression activities.

Clinician: a registered nurse or designated allied health care professional.

Comfort Scale: pain scale that can be used when a patient cannot self-report their pain. It can be used in children or adults and consists of nine parameters.

Comprehensive Pain Assessment: individualized pain assessment conducted on admission, with change of caregiver, with each new location of pain and per standard of care for appropriate population. Components of the assessment may include description of pain: location, intensity/severity, quality, onset, aggravating and alleviating factors, and effect on function (i.e. able to participate in care).

Coping Scale: used in labor and delivery to measure how the patient is able to cope with the discomforts of labor.

Critical Care Pain Observation Tool (CPOT): a validated tool used to scale the pain of patients unable to report it themselves.

The Face, Legs, Activity, Cry, Consolability (FLACC) Scale: is used to assess pain for children between the ages of 2 months and 7 years or individuals that are unable to communicate their pain.

Interventions:

- **Analgesic administration:** the use of pharmacologic agents to reduce or eliminate pain

Integrative Therapy is a holistic approach to health care that treats the **whole person**, recognizing that every aspect of life contributes to healing. Integrative care bridges the gap between traditional and alternative medicine. Banner Health facilities and clinics offer a variety of integrative care programs administered by team members who have received education/training in the area:

Continued on next page

Introduction, Continued

Definitions, continued

- Acupuncture
- Aromatherapy
- Healing touch
- Guided imagery
- Massage therapy
- Reiki therapy
- Music therapy
- Spiritual care
- Dog therapy
- Medical play therapy

Licensed Practitioner (LP): Any individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. (Joint Commission 2018).

Multimodal analgesia: combines analgesics from two or more drug classes or analgesic techniques, and/or nonpharmacologic interventions that act by different mechanisms for providing analgesia. Examples of drug classes that might be used would be opioids, nonopioid analgesics (acetaminophen and nonsteroidal anti-inflammatories), gabapentinoids, serotonin norepinephrine reuptake inhibitors, tricyclic antidepressants and NMDA receptor antagonists. Physical and behavioral health interventions are also a part of multimodal analgesic strategies. (Polomano, et al., 2017)

NPASS: neonatal pain, agitation and sedation scale.

Pain Champion: a registered nurse who receives additional and ongoing education in pain management. This allows one to function as both a resource and a change agent in disseminating information, interfacing with nurses, physicians, other health care providers, and patients and families to facilitate quality pain management.

Pain Expert: Trained professionals who specialize in pain management, such as Advanced Practice Nurses, Pharmacists, and Certified Pain Management Nurses.

Pain Management: Pain management encompasses pharmacological and non-pharmacological approaches to manage pain.

Pain Severity descriptors (mild, moderate, and severe) are based on pain medication administration orders only.

- **Mild pain:** Pain is present but does not impair function (generally considered 1-3 on pain scale). Pain management effective.

Continued on next page

Introduction, Continued

Definitions, continued

- **Moderate pain:** Pain is tolerable but causes significant discomfort and/or impairs function (generally considered 4-7 on pain scale). Pain management partially effective. Needs intervention.
- **Severe pain:** Pain is intolerable, and the patient is unable to do anything because of pain (generally considered 8-10 on pain scale). Pain management ineffective, needs urgent intervention.

Pasero Opioid-Induced Sedation Scale (POSS): A valid, reliable tool used to assess sedation when administering opioid medication to manage pain.

Placebo: any medication or procedure that produces an effect in a patient because of its implicit or explicit intent not because of its' specific physical or chemical properties (Pasero & McCaffery, 2011).

Reassessment interval: Refers to when a patient should be reassessed following a pharmacologic or nonpharmacologic intervention for pain management. Analgesic efficacy is variable, and reassessment can be increased or decreased based on drug and or formulation.

- **Pain must be assessed and reassessed post intervention with the use of the numeric pain scale or other scale as appropriate.**

Richmond Agitation-Sedation Scale (RASS): a medical scale used to measure the agitation or sedation level of a patient.

Policy

Philosophy

Banner Health's pain management philosophy is based on the following precepts:

- Pain will be managed to maximize the patients comfort in the safest manner possible.
 - The patient is the best person to describe and rate his or her pain.
 - The patient has a valuable role in the treatment and management of his or her pain.
 - Pain management affects quality of care and consumer satisfaction.
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Policy, Continued

Pain management

1. Pain management is a priority for Banner Health.
2. Clinicians:
 - Perform pain assessments on patients.
 - Minimize risk associated with treatment.
 - Involve the patient in developing realistic expectations and goals for pain management.
 - Include functional ability in their assessment and plan for pain management.
 - Develop a pain treatment plan based on evidence-based practices.
 - Use standardized validated rating scales and/or behavioral tools.
 - Document the efficacy of pain relief at appropriate intervals after starting or changing treatment.
 - Provide information about pain management to patients and families.
 - Provide opioid safety education to patients and families.
 - Perform pain reassessments and sedation/respiratory assessment (POSS).
3. When changes in pain patterns or new pain develop, it will be reported to the LP for further evaluation and consideration for modification of the treatment plan.
4. Placebos are only given if a patient is enrolled in a clinical trial and an informed consent has been obtained.

For patients who can self-report

Clinicians ask about pain and use the patient's self-report as the primary source of the assessment. Self-report is based on a scale appropriate to the patient population such as the following scales:

- Numeric Rating Scale (NRS)
- FACES – used for children and adult patients
- Effect on function (able to participate in care)

Coping Scale: used in labor and delivery to measure how the patient is able to cope with discomforts of labor. Use this scale for patients in pain from contractions to identify how they are tolerating natural childbirth experience utilizing the non-pharmacological interventions to assist with pain.

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Policy, Continued

**For patients
unable to self-
report,
continued**

For patients who are unable to self-report, all of the following may be used to assess pain:

- Utilize the Hierarchy of Pain Assessment Techniques (see Appendix A).
 - CPOT: Critical Care Pain Observation Tool
 - NPASS for the neonatal population
 - FLACC
 - Comfort Scale

 - The clinician assumes pain is present when painful pathologic conditions are present, or a procedure is performed (see Appendix B).
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Procedure

General pain management

1. Complete a comprehensive pain assessment. Evaluate, and document the patient's pain and findings as follows:
 - On admission (within 4 hours of admission order),
 - With change of care giver,
 - With each report of new location of pain, and
 - Per standard of care for appropriate population

Note: Portions of this assessment are completed by the most appropriate member of the interdisciplinary team.
2. Develop an individualized pain treatment plan involving the patient to include realistic expectations, measurable goals, and pain education regarding opioid safety and the rationale for frequent monitoring of pain and sedation.
3. Using clinical decision making, consider assessment of patient function, patient response to medical plan (efficacy, respiratory status, sedation level) and pain intensity in determining mild, moderate or severe pain interventions. Note: Assessments for mild, moderate or severe pain interventions which consider function and efficacy of prior medication may indicate an appropriate medication dose that is different from using the numeric pain rating score alone. Document rationale for alternative dose. An example would be dosing for anticipatory pain.
4. Provide multimodal pharmacological and/or non-pharmacological interventions as appropriate.
5. Instruct patient to report changes in their pain or any new pain or new location so that appropriate reassessment and changes in the treatment plan can be initiated.
6. Observe patients who are unable to self-report using the Hierarchy of Pain Assessment Techniques and document observations.
7. Consult with the pain champion and/or pain expert, or appropriate provider for interventions to assist in bringing the patient's pain to an acceptable level.
8. Reassess the patient after opioid administration: this is a routine part of the ongoing patient assessment to identify any adverse side effects. Note that sedation and respiratory depression should be routinely assessed at the peak effect of the medication. Refer to table below for guidelines on peak effect of opioids. Note that patient response may be variable.

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Procedure, Continued

General pain management, continued

Opioid	Route	Peak effect	Duration
Morphine	IV PO MS Contin (sustained release)	0.5-1 hour 1-2 hours NA	3-4 hours 3-6 hours 8-12 hours
Hydromorphone	IV PO	0.5-1 hour 1-2 hours	3-4 hours 3-6 hours
Fentanyl	IV Duragesic Patch	<10 minutes 12-24 hours	30-60 minutes 72 hours
Methadone	PO	1-2 hours	6-8 hours
Oxycodone	PO SR Oxycodone	0.5-1 hours NA	3-6 hours 12 hours
Codeine	PO	1-1.5 hours	4-6 hours
Hydrocodone with acetaminophen	PO	1-2 hours	4-6 hours

9. Reassess pain for effectiveness of the pharmacologic and nonpharmacologic intervention within 60 minutes. Consider effect on function as well as pain severity/pain behaviors in the reassessment.
10. For scheduled pain medications, do not hold the medication for low pain scores, but do hold for sedation.

Procedure, Continued

Sedation assessment

1. Unintended respiratory depression is a serious opioid adverse effect. In the majority of patients, sedation precedes respiratory depression. To properly assess a patient:
 - Use the Pasero Opioid-Induced Sedation Scale (POSS) in pediatric and adult patients to perform a sedation assessment (Appendix C) on patients receiving opioid analgesia. The POSS is to be assessed pre and post opioid administration including scheduled opioids. The POSS is not to be utilized for patients receiving or recovering from intentional sedation/anesthesia. The Neonatal Pain Agitation Sedation Scale (NPASS) is utilized in the NICU for both intentional and unintentional sedation.
 - Use the RASS for assessment of sedation and agitation, in particular for the mechanically ventilated patients
 - The patient should be stimulated to wake up for accurate assessment of sedation. If they have received medication for sedation and for at least the first 24 hours post operatively, they must be stimulated to wake up. If on a stable dose of opioids for greater than 24 hours and respirations are quiet with normal depth, rate and regularity, then patient may be allowed to sleep.
 - Respiratory assessment is a critical part assessing a patient receiving an opioid and includes:
 - the rate
 - depth
 - regularity of respirations
 - respiratory characteristics
 - monitor for obstructive upper airway sounds
 - apnea
 - Based on the POSS score follow appropriate intervention. With unintended respiratory depression, the clinician should be prepared to stimulate patient, support their airway, and consider a reversal agent (see Appendix C).
 - Consider more vigilant monitoring of sedation and respiratory status when patients may be at higher risk for opioid induced respiratory depression. Risk factors may include known or suspected obstructive sleep apnea, obesity hypoventilation syndrome, cardiac or pulmonary disease, advanced age, continuous opioid infusion, co-administration of other sedating medications such as benzodiazepines and the 1st 24 hours following general surgery.
 - For reversal agents see Appendix D.
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Other Information

Documentation Include the following items when documenting pain assessment and management:

- Assessment of pain
- Interventions and teaching
- Patient/family's response to interventions and teaching
- Reassessment with opioid administration to include:
 - Pain intensity with patient able to self-report
 - Hierarchy of Pain assessment techniques with patient unable to self-report
 - Sedation assessment with the POSS for unintentional sedation from opioid analgesia.
 - Respiratory assessment that includes respiratory characteristics and monitoring for obstructive upper airway sounds.

Additional Information

1. Staff with expert knowledge of principles of pain management may be available for consultations on complex pain patients. This includes but not limited to providers, clinical pharmacists, Registered Nurses (RNs) certified in pain management, Child Life Specialists, and complementary therapies.
2. The majority of patients with pain greater than 5 (on a scale of 0 to 10) for 24 hours or more have problems with activities of daily living (ADLs), sleep, nutrition, and the ability to cope.
3. Consider providing multimodal analgesia interventions prior to painful activities or procedures expected to increase discomfort (i.e. wound care, postoperative ambulation, participation in therapy).
4. An analgesic regimen consisting of (routine), around-the-clock analgesics with PRN supplemental analgesics (unless not medically indicated) is often the best way to treat continuous pain (Pasero & McCaffery, 2011).
5. "Compared with opioid naïve individuals, opioid tolerant individuals are able to tolerate faster escalation in larger doses of opioid drugs without experiencing life-threatening side effects." (Pasero & McCaffery, 2011, p. 294).
6. Prior to administering any opioid, consider clinical factors that influence opioid dose requirement: age, sedation level, respiratory status, functional status, tolerance, reaction/response to prior opioid treatment, comorbidities. Notify LP of any concerns.

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Other Information, Continued

**Additional
Information,**
(continued)

7. Regardless of the type of pain being treated, opioids should be administered by the least invasive and safest route capable of producing satisfactory analgesia. (Pasero, Quinn, Portenoy, et al., 2011)
 - Choosing the **oral route** is preferred over other routes because it is relatively safe, convenient, and inexpensive. (Pasero & McCaffery, 2011). Even post-op pain can be managed better with oral opioids and can reduce length of stay (Pasero & McCaffery, 2011).
 - The **IV route** produces a faster onset but a much shorter duration of analgesia with high plasma peak effects compared with the oral route. Peak effects are associated with increased side effects, such as sedation and nausea, and tend to be followed by low troughs in plasma concentration during which pain returns (Pasero, Quinn, Portenoy, et al., 2011).
 - If pain is severe and a rapid onset of analgesia is desired, the IV route can be used for rapid titration with close monitoring; the patient can be transitioned to the oral route when pain is under control and patient is able to tolerate oral intake.
 8. Adults who have cognitive impairment or other communication difficulties pose assessment challenges and are at risk for under-treatment. (Pasero & McCaffery, 2011).
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Other Related Policies, Keywords, Appendix

See also

Please see the following associated policies for further information

[Adult Patient Care](#)

[Aromatherapy](#)

[Banner Health Perianesthesia Guidelines](#)

[Healing Touch](#)

[Hospice - Music Therapy Services](#)

[Hospice - Pain Management](#)

[Management of a Patient with Temporary Implanted Pain Management System](#)

[Medication Orders](#)

[Neuraxial Analgesia \(Epidural and Intrathecal\) in the Non-Laboring Patient](#)

[Pain Management - Patient Controlled Analgesia \(PCA\) and/or Basal Infusion for the Non-Sedated Patient](#)

[Pain Management for Needle Insertion Procedures in the Adult Patient](#)

[Pediatric Patient Guidelines](#)

[Procedural Sedation for Therapeutic and Diagnostic Procedures](#)

[Rehabilitation - Cryotherapy Guidelines](#)

[Therapy Dog Program and Pet Visitation](#) [Sucrose Use in Neonates for Pain Relief](#)

Keywords

Assessment

CPOT

FACES

FLACC

NPASS

NRS

Numeric Rating Scale

Pain

Pain Management

PIPA

POSS

Self-Report

Appendix

Appendix A: Hierarchy of Pain Assessment Techniques

Appendix B: Behavioral Tools for Patients Unable to Self-Report

Appendix C: Pasero Opioid-Induced Sedation Scale and Interventions (POSS)

Appendix D: Reversal Agent for Opioids

Appendix E: Clinical Application of Mild, Moderate, and Severe PRN Pain Medications

Appendix A: Hierarchy of Pain Assessment Techniques

1. Always attempt to Obtain Self-Report.
2. Search for Potential Causes of Pain.
3. Observe Patient Behavior. (CPOT, FLACC, APP, NPASS, PIPA)
4. Surrogate Report.
5. Attempt an analgesic trial.

[Adapted from the Pain Assessment and Pharmacologic Management, 2011]

Appendix B: Behavioral Tools for Patients Unable to Self-Report

1. Assume Pain Present (APP): Use for all adults unable to self-report, use with patients receiving intentional sedation, and or neuromuscular blockade. Adult ICU: ICU will use APP with existing Critical-Care Pain Observation Tool (CPOT)
 2. Pediatric: FLACC Revised (Faces, Legs, Activity, Crying, Consolability) - ages 0 months – 3 years and up to 18 years of age who cannot self-report
 3. Neonatal: Neonatal Pain Agitation Sedation Scale (NPASS) and Preterm Infant Pain Assessment (PIPA) for newborn pain assessment
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Appendix C: Pasero Opioid-Induced Sedation Scale and Interventions (POSS)

Non-intentional Sedation POSS Interventions

S = Sleep, easy to arouse

Acceptable; no action necessary; may increase opioid dose if needed and order exists

1=Awake and alert

Acceptable; no action necessary; may increase opioid dose if needed and order exists

2 = Slightly drowsy, easily aroused

Acceptable; no action necessary; may increase opioid dose if needed and order exists

3 = frequently drowsy, arousable, drifts of to sleep during conversation

a) Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 & respiratory status is satisfactory

b) Notify provider to recommend and obtain order to decrease opioid dose 25-50%

c) Consider administering a non-sedating, non-opioid analgesic if not contraindicated and order exists

4 = Somnolent, minimal or no response to verbal and physical stimulation

a) Unacceptable, stop opioid

b) Consider administering naloxone (Emergency Response Protocol)

c) Monitor Respiratory Status and sedation level closely until sedation level is than 3 and respiratory status is satisfactory

d) If indicated call Rapid Response Team or Code Blue



Appendix D: Reversal Agent for Opioids

Agent	Dose	Onset	Duration	Characteristics	Warnings / Adverse Reactions
Complete Reversal of Opioids					
Naloxone (Narcan)	<p>Adults: Lower doses, such as 0.1-0.2 mg should be considered in narcotic dependent patients and to reverse post-procedural narcotic depression.</p> <p>Higher dosage regimens of 0.4-2 mg every 2-3 minutes (rate not to exceed 0.4 mg over 15 seconds) should be considered in patients where over-sedation poses a significant risk to patient.</p> <p>Pediatrics: Consider lower dose regimen as per adult recommendations above.</p> <p>For higher dosage regimens consider 0.1 mg/kg/dose (not to exceed 2 mg) every 2-3 minutes based on response.</p>	<p>IV: 1-2 minutes</p> <p>IM/SC: 2-5 minutes</p>	20-60 minutes	<p>Reverses CNS and respiratory depression in suspected narcotic overdose.</p> <p>Re-sedation may occur if patient has received an agent with a longer duration of action than naloxone</p>	<p>Warning: May precipitate withdrawal symptoms: Use with caution in patients on opioids for chronic pain relief (lower dose increments such as 0.1-0.2 mg are recommended)</p> <p>May cause hypertension, hypotension, tachycardia, arrhythmias, nausea, vomiting, sweating, pulmonary edema</p>

Reversal Agent for Respiratory Depression Due to Opioids: Naloxone

- Used for unintentional sedation with decreased level of consciousness.
- Give for respiratory rate:
 - Less than 8 in adults
 - Less than 10 in pediatrics associated with decreased effectiveness of breathing

Adults:

- Mix 0.4 mg naloxone / 9 mL 0.9% NaCl
- Give 0.5 mL every 2 minutes, titrate to effect (until return of desired respiratory rate).

Pediatrics: 0.01 mg/kg over 2 minutes, titrate to effect (until return of desired respiratory rate).

Note: May need to repeat dose as 30 minute duration of naloxone is shorter than duration of most opioids

Appendix E: Clinical Application of Mild, Moderate, and Severe PRN Pain Medications

Clinical application of mild, moderate and severe PRN pain indications:

Using clinical decision making, consider assessment of patient function, patient response to medical plan (efficacy, respiratory status, sedation level) and pain intensity *in determining mild, moderate or severe pain interventions*. Pain intensity will most often guide the choice. Note: Assessments for mild, moderate or severe pain interventions which consider function and efficacy of prior medication may indicate an appropriate medication dose that is different from using the numeric pain rating score alone. Examples may be medicating for anticipatory pain for mobility or for procedure/dressing change.

If multimodal therapy is utilized by the same route and the pain scales overlap then the clinician shall utilize non-opioid medications first as a pain control option before progressing to opioid therapy, unless otherwise noted in the order by the provider.

Pain Severity descriptors:

- **Mild pain:** Pain is present but does not impair function (generally considered 1-3 on pain scale). Pain management effective.
 - **Moderate pain:** Pain is tolerable but causes significant discomfort and/or impairs function (generally considered 4-7 on pain scale). Pain management partially effective. Needs intervention.
 - **Severe pain:** Pain is intolerable, and the patient is unable to do anything because of pain (generally considered 8-10 on pain scale). Pain management ineffective, needs urgent intervention.
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