

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 McKee Medical Center Banner North Colorado 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 Ogallala Community Hospital Page Hospital Platte County Hospital Sterling Regional Medical Center Torrington Community Hospital Washakie Medical Center Wyoming Medical Center</p>		

I. Purpose and Population:

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

II. Definitions:

- A. **Anticipatory pain:** Anticipated nociceptive event (procedures, therapies).

- B. **APP- Assume Pain Present:** Use for patients unable to self-report and pain is suspected (presence of pathology or procedures that are normally painful).
- C. **Behavioral Scales:** Pain assessment scales that are used to indicate the potential presence of pain in patients unable to self-report. Available tools include: CPOT, FLACC, PainAD, NPASS, Comfort Scale).
- D. **Child Life Specialist:** Trained professionals with expertise in helping children and their families cope with hospitalization through play, preparation, education, and self-expression activities.
- E. **Clinician:** A registered nurse or designated allied health care professional.
- F. **Comfort Scale:** Behavioral pain scale used for ventilated infants, children and adolescents.
- G. **Comprehensive Pain Assessment:** Individualized pain assessment. 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).
- H. **Coping Scale:** Used in labor and delivery to measure how the patient is able to cope with the discomforts of labor.
- I. **CPOT - Critical Care Pain Observation Tool:** A behavioral pain assessment tool used to rate the pain of critically ill patients unable to report it themselves.
- J. **FACES:** A self-report tool where the cognitively intact adult or child (3 years and older) chooses a face that best expresses the physical pain they are experiencing. The face correlates to the numeric scale with scores of 0 to 10.
- K. **FLACC: Face, Legs, Activity, Cry, Consolability Scale:** Used to assess pain for children between the ages of 2 months and 7 years (or for children up to 18 years if they are unable to self-report).
- L. **Integrative Therapy:** 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 one or more of these areas: Acupuncture, Aromatherapy, Healing touch, Guided imagery, Massage therapy, Medical play therapy, Music therapy, Reiki therapy, Spiritual care, dog therapy.
- M. **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).
- N. **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, gabapentinoids, serotonin norepinephrine reuptake inhibitors, tricyclic antidepressants, and NMDA receptor antagonists. Nonpharmacologic, physical (ex. massage and or ice or heat), and behavioral health interventions (ex. music, distraction techniques, mindfulness) are also a part of multimodal analgesic strategies. (Polomano, et al., 2017)
- O. **NPASS - Neonatal Pain, Agitation and Sedation Scale:** Pain and sedation scale used for term and preterm neonates.
- P. **NRS - Numeric Rating Scale:** A unimodal numeric scale that ranks the intensity of the pain for cognitively intact an adult or child able to understand rank order numbers and communicate their level of pain intensity.
- Q. **PainAD: Pain in patients with Advanced Dementia.** A behavioral pain assessment tool that is used with patients unable to self-report pain with advanced dementia and delirium, primarily age > 65. Many hospitals utilize this tool for adult dying patients as well.
- R. **Pain Expert:** Trained professionals who specialize in pain management, such as Advanced Practice Nurses, Pharmacists, and Certified Pain Management Nurses.

- S. **Pain Management:** Pain management encompasses pharmacological and non-pharmacological approaches to manage pain.
- T. **Pain severity descriptors:** mild, moderate, and severe. Based on pain medication administration orders only.
 - 1. **Mild pain:** Pain is present but does not impair function (generally considered 1-3 on pain scale). Pain management effective.
 - 2. **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.
 - 3. **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.
- U. **Pasero Opioid-Induced Sedation Scale (POSS):** A valid, reliable tool used to assess sedation when administering opioid medication to manage pain.
- V. **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).
- W. **Reassessment:** The clinical procedure of assessing the patient after a non-pharmacologic or pharmacologic intervention to evaluate the effectiveness of treatment or to detect any adverse effects of the treatment. The same scale used to evaluate the patient prior to the intervention should be used for assessment after. Components of the reassessment may include the description of pain: Intensity, numeric rating scale, pain impact on function, patient's acceptable numeric pain score. Reassessment of the patient after opioid administration should also include respiratory and sedation assessment.
- X. **RASS - Richmond Agitation-Sedation Scale:** A medical scale used to measure the agitation or sedation level of a patient.
- Y. **Sedation Assessment:** The clinical procedure of sequentially assessing the patient's level of sedation using a valid and reliable tool as part of the routine and ongoing assessment after the administration of any opioids.

III. Policy:

- A. **Philosophy:** Banner Health's pain management philosophy is based on the following precepts:
 - 1. Pain will be managed to maximize the patients comfort in the safest manner possible.
 - 2. The patient is the best person to describe and rate his or her pain.
 - 3. The patient has valuable role in the treatment and management of his or her pain.
 - 4. Pain management affects quality of care and consumer satisfaction.
- B. **Pain Management:**
 - 1. Clinicians
 - a. Perform pain assessments on patients.
 - b. Minimize risk associated with treatment.
 - c. Involve the patient in developing realistic expectations and goals for pain management.
 - d. Develop a pain treatment plan based on evidence-based practices.
 - e. Use standardized validated rating scales and/or behavioral tools.
 - f. Document the efficacy of pain relief at appropriate intervals after starting or changing treatment.
 - g. Perform pain assessments/reassessments, sedation assessments/reassessments (POSS, RASS, NPASS) and respiratory assessments/reassessments.

- h. Provide information about pain management and opioid safety education to patients and families.
 2. When changes in pain patterns or new pain develops, it will be reported to the LIP for further evaluation and consideration for modification of the treatment plan.
 3. Placebos are only given if a patient is enrolled in a clinical trial and an informed consent has been obtained.
 - C. **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:
 1. Numeric Rating Scale (NRS)
 2. FACES – children and adult patients
 3. Effect on function (able to participate in care)
 4. Coping Scale (labor and delivery)
 - D. **Patients unable to self-report:** In the absence of the ability to self-report, observation of behavior is a valid alternative approach for pain assessment.
 1. Behavioral pain assessment tools have been validated for different populations. Interpretation of pain behaviors and decisions regarding treatment require careful consideration of context in which pain behaviors are observed. It is important to select the most appropriate behavioral scale to assess pain in a specific patient population.
 - a. CPOT: Critical Care Observation Tool
 - b. PAINAD (dementia, end of life)
 - c. FLACC (children)
 - d. Comfort Scale (children)
 - e. NPASS (neonatal population)
 2. Behavioral pain assessment tools can be helpful to identify the presence of pain when painful pathologic conditions are present, a painful procedure is performed; to monitor for changes in pain, and to evaluate the effectiveness of pain treatments.
 3. A score from a behavioral pain tool IS NOT equivalent to a self-report of pain intensity. An increasing score usually indicates increasing pain/discomfort. Decreasing score potentially represents a decrease in pain/improved comfort.
 4. An analgesic trial (administering pain medication) should be initiated if behavioral scores indicate the presence of pain. The trial can be part of the assessment process to establish whether pain is the cause of the behaviors.
 5. Assume Pain Present (APP): Is used with patients who are unable to exhibit behaviors (e.g. receiving intentional sedation, and or neuromuscular blockade).

IV. Procedure:

A. General Pain Management

1. Complete a comprehensive pain assessment upon admission. [Adult Patient Care v.27 \(policytech.com\)](http://policytech.com). Ongoing assessment for the presence or absence of pain is completed by a clinician at a minimum of every shift or more often as patient condition warrants.

- a. The nurse assesses the patient's pain before and after giving an analgesic, and administers medication per provider order considering the following:
 - i. Pain intensity (numeric or faces score).
 - ii. Pain Severity descriptors/function:
 - (i) **Mild pain:** Pain is present but does not impair function (generally 1-3).
 - (ii) **Moderate pain:** Pain is tolerable but causes significant discomfort and/or impairs function (generally 4-7).
 - (iii) **Severe pain:** Pain is intolerable, and the patient is unable to do anything because of pain (generally 8-10).
 - iii. Patient response to previous medications (effectiveness, respiratory status, sedation, or other adverse events).
2. 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. Contact provider for lower dose. If dosing for anticipatory pain; Document reason for higher dose. Do not exceed highest dose ordered.
3. Develop an individualized pain treatment plan involving the patient to include realistic expectations, measurable goals, reporting of changes in pain, pain education regarding opioid safety, and the rationale for frequent monitoring of pain and sedation. The nurse may use the patient's identified acceptable pain intensity score as part of collaboratively planning pain interventions with the patient.
4. Provide multimodal pharmacological and/or non-pharmacological interventions as appropriate.
5. 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.
6. For scheduled pain medications, do not hold the medication for low pain scores, but **do hold for sedation**.
7. Reassess the patient after analgesic administration (opioid and non-opioid). This is a routine part of the ongoing patient assessment to identify any adverse side effects.
 - a. Consider effect on function as well as pain severity/pain behaviors in the reassessment.
 - b. If upon reassessment the patient's pain is not reduced, relieved or at their desired acceptable pain intensity rating, implement additional interventions or contact the provider.
8. 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.

B. Sedation Assessment

1. **Unintended respiratory depression is a serious opioid adverse effect.** In many patients, sedation precedes respiratory depression. The post-opioid administration

sedation assessment should be clinically performed as part of the routine ongoing reassessment when a patient is receiving opioids.

- a. Use the Pasero Opioid-Induced Sedation Scale (POSS) in pediatric and adult patients to perform a sedation assessment (Appendix B).
 - i. The POSS interventions are not appropriate for patients receiving or recovering from intentional sedation/anesthesia.
 - ii. Use the Neonatal Pain Agitation Sedation Scale (NPASS) in the NICU for both intentional and unintentional sedation.
 - iii. Use the RASS for assessment of sedation and agitation, in particular for the mechanically ventilated patients.
- b. The patient is at increased risk for adverse events including unintended opioid induced over-sedation. Monitoring during this time is crucial:
 - i. First 24 hours of initiating opioid therapy.
 - ii. First 24 hours post-surgery/procedure.
 - iii. Concurrent use of benzodiazepines.
- c. If the patient has received opioids they should be stimulated and awoken from sleep to accurately assess their level of sedation for at least the first 24 hours post operatively. (Snoring may indicate unintended oversedation).
- d. With unintended respiratory depression, the clinician should be prepared to stimulate patient, place in full upright position if allowed, support their airway, and consider a reversal agent (see Appendix C).
- e. Respiratory assessment is a critical part assessing a patient receiving an opioid and may include:
 - i. Rate
 - ii. Depth
 - iii. Quality
 - iv. Regularity of respirations
 - v. Apneic periods
 - vi. Monitor for obstructive upper airway sounds (snoring or sonorous respirations)
 - vii. Oxygen saturation
 - viii. End tidal CO₂ (may be used if available)
- f. 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:
 - i. Known or suspected obstructive sleep apnea.
 - ii. Obesity hypoventilation syndrome.
 - iii. Cardiac disease.

- iv. Pulmonary disease.
- v. Advanced age.
- vi. Continuous opioid infusion and PCA.
- vii. Co-administration of other sedating medications such as benzodiazepines.
- viii. The first 24 hours following general surgery.
- ix. Sonorous (snoring) respirations may indicate unintended oversedation or a partially obstructed airway.
- x. Following a dosage increase.
- g. For reversal agents see *Appendix C*.

V. Procedural Documentation:

- A. Include the following items when documenting pain assessment and management:
 - 1. Comprehensive pain assessment upon admission to an inpatient setting.
 - 2. Ongoing pain assessment a minimum of every shift and as patient condition warrants.
 - 3. Patient/family teaching: this may include IPOC, Patient Education iView and/or Krames education.
 - 4. Pain reassessment after pain intervention.
- B. For Patients receiving opioids or other sedating medications include the following:
 - 1. Sedation reassessment.
 - 2. Respiratory characteristics.
 - 3. End tidal CO₂ if utilized.

VI. Additional Information:

- A. Consider providing multimodal analgesia interventions prior to painful activities or procedures expected to increase discomfort (i.e., wound care, postoperative ambulation, participation in therapy).
- B. 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).
- C. 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.
- D. 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)
 - 1. Choosing the **oral route** is preferred over other routes because it is relatively safe, convenient, and inexpensive. (Pasero & McCaffery, 2011). Even postoperative pain can be managed better with oral opioids and can reduce length of stay (Pasero & McCaffery, 2011).
 - 2. 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).
3. 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.
- E. Adults who have cognitive impairment or other communication difficulties pose assessment challenges and are at risk for under-treatment. (Herr et al., 2019)

VII. References:

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VIII. Other Related Policies/Procedures:

- A. [Adult Patient Care](#)
- B. [Aromatherapy](#)
- C. [Perianesthesia Guidelines](#)
- D. [Healing Touch](#)
- E. [Hospice - Pain Management](#)
- F. [Management of a Patient with Temporary Implanted Pain Management System](#)
- G. [Medication Orders](#)
- H. [Neuraxial Analgesia \(Epidural and Intrathecal\) in the Non-Laboring Patient](#)
- I. [Pain Management - Patient Controlled Analgesia \(PCA\) and/or Basal Infusion for the Non-Sedated Patient](#)
- J. [Pain Management for Needle Insertion Procedures in the Adult Patient](#)
- K. [Pediatric Patient Care](#)
- L. [Procedural Sedation for Therapeutic and Diagnostic Procedures](#)
- M. [Rehabilitation - Cryotherapy Guidelines](#)
- N. [Therapy Dog Program and Pet Visitation](#)
- O. [Neonatal Sucrose for Pain Relief](#)

IX. Keywords and Keyword Phrases:

- A. Assessment
- B. CPOT
- C. FACES
- D. FLACC
- E. NPASS
- F. NRS
- G. Numeric Rating Scale
- H. Pain
- I. Pain Management
- J. PIPP
- K. POSS
- L. Self-Report

X. Appendix:

- A. Appendix A: Hierarchy of Pain Assessment Techniques
- B. Appendix B: Pasero Opioid-Induced Sedation Scale and Interventions (POSS)
- C. Appendix C: Reversal Agent for Opioids
- D. Appendix D: Clinical Application of Mild, Moderate, and Severe PRN Pain Medications

Appendix A: Hierarchy of Pain Assessment Techniques

- A. Use the Hierarchy of Pain assessment Techniques
 - a. Be aware of potential causes of pain including known painful interventions.
 - b. Attempt self-report.
 - c. Observe patient behaviors.
 - d. Solicit reporting of pain and behavior/activity changes.
 - e. Attempt analgesic trial.
- B. Utilize behavioral pain assessment tools, as appropriate.
- C. Minimize emphasis on vital signs.
- D. Assess regularly, reassess post intervention, and document.

Herr, K., et al. (2019). ASPMN 2019 Position Statement: Pain Assessment in the Patient Unable to Self-Report.

Appendix B: 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 off to sleep during conversation

- A. Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and 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 less than 3 and respiratory status is satisfactory.
 - D. If indicated, call Rapid Response Team or Code Blue.
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Appendix C: Reversal Agent for Opioids

Reversal Agent for Respiratory Depression due to opioids: Naloxone

- A. Used for unintentional sedation with decreased level of consciousness.
- B. Give for respiratory rate:
 - a. Less than 8 in adults.
 - b. Less than 10 in pediatrics associated with decreased effectiveness of breathing.
- C. Adults:
 - a. Mix 0.4 mg naloxone with 9 ml 0.9% NaCl.
 - b. Give 0.5ml every 2 minutes, titrate to effect (until return of desired respiratory rate).
- D. Pediatrics:
 - a. 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 D: Clinical Application of Mild, Moderate, and Severe PRN Pain Medications

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

- A. 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.
- B. Pain intensity will most often guide the choice.
- C. 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.
- D. Examples may be medicating for anticipatory pain for mobility or for procedure/dressing change.

Pain Severity Descriptors

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