

# Pain Management Protocol Content

The following recommendations for the content of a pain management protocol can be used to identify opportunities for improvement in an organization's current pain management protocol.

## Order Sets

- Range orders follow American Society of Pain Management Nursing (ASPMN) and American Pain Society (APS) recommendations
- Set limits for number and types of drugs

## Drug Dosing

- Maximum dose no greater than 2-4 times the minimum dose
- Indicate intervals between doses and incremental increases in doses
- Limit acetaminophen dosage to 325 mg/tablet or capsule and 4000 milligrams/day or less<sup>1</sup>
- Dose in milligrams (mg), not milliliters (mL) to decrease risk of inadvertent dosing errors
- Use equianalgesia tables with caution; establish periodic reviews and updates approved by a pharmacy and therapeutics committee
  - When changing medications, (e.g., from one product to another) decrease initial dose of new medication by 25%-50%

## PCA (Patient Controlled Analgesia)

- Basal rates for opioid tolerant patients only
- Centralized continuous pulse oximetry monitoring
- Exclusion criteria – e.g., unable to understand PCA, physically unable to use
- PCEA (Patient Controlled Epidural Analgesia) — provide 24/7 anesthesia or pain management consultation coverage
- No PCA by proxy

## Specified changes to dosing/lockout intervals

- Change dose if medication has short peak action and there has been no/little pain relief
- Change interval if pain increases near end of lockout time

## Specialty/Setting-Specific Modifications

- Options for opioid-tolerant patients<sup>2</sup>
- Opioid titration in patients with regional blocks
- Patients with OSA

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<sup>1</sup> Current (January 13, 2011) FDA recommendation for maximum dose is 4G (4000 milligrams)/day; however, a further decrease to 3000 milligrams/day is anticipated.

<sup>2</sup> Opioid-tolerant patients are defined as patients who have been taking 60mg morphine/day OR 30mg oral oxycodone OR 8mg oral hydromorphone/day for the week immediately preceding (if off less than one week, still consider opioid-tolerant) OR equianalgesia of other opioid.

- Opioid naïve patients should not receive long-acting opioids, fentanyl patches, buccal tablets, dosing by intranasal route

### Multimodal Therapy Options

- Differing dosage forms
- Scheduled use of adjunctive pain therapies (gabapentin) and non-opioid pain medications (acetaminophen, non-steroidal anti-inflammatory drugs)
- Local anesthetic infiltration
- Non-pharmacologic methods

### Indicators for Pharmacist Consultation

- Identify drug and/or doses that would trigger a pharmacist review (e.g., fentanyl patches, >1mg IV hydromorphone)

### Indicators for Acute Pain Management Specialty Consultation

- Pain-Sedation mismatch (excessive pain in presence of high sedation)
- Sub-optimal pain control in chronic pain patient, or patient with history of opioid-related adverse drug event
- Difficult pain control in any patient

### Valid Population-Specific Sedation Assessment Tools\*

- Pasero Opioid Sedation Scale (POSS) – medical/surgical patients
- Richmond Agitation Sedation Scale (RASS) – intensive care patients

### Sedation and Respiratory Depression Monitoring Policies

- Identify intervals for monitoring with criteria for increasing or decreasing intervals based on patient status
- Use a valid and reliable sedation assessment scale
- Define serial assessments for trending of sedation and respiratory depression that include:
  - Respiratory rate, depth, regularity
  - Presence of apneic periods, snoring, and arousal status
  - SpO<sub>2</sub>, ETCO<sub>2</sub>
- Establish criteria for use of electronic monitoring, including indications for telemetry
- Definition of alarm thresholds and notifications

\* Pasero, C. (2009). Assessment of sedation during opioid administration for pain management. *Journal of PeriAnesthesia Nursing*, 24(3), 186-190.

Sessler CN, Gosnell MS, Grap MJ, Brophy GM, O'Neal PV, Keane KA, Tesoro EP, & Elswick RK. (2002). The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care unit patients. *American Journal of Respiratory Critical Care Medicine*. 166 (10), 1338-1344. doi: 10.1164/rccm.2107138. Retrieved from: <http://ajrccm.atsjournals.org/content/166/10/1338.full.pdf+htm>