

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Huachuca, Arizona 85613-7040

MEDDAC MEMORANDUM
No. 40-163

25 February 2008

MEDICAL SERVICES
Pain Management

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1. HISTORY: This issue publishes a revision to this publication.

2. PURPOSE: It is the policy of this organization to respect and support the patient's right to optimal pain assessment, management, and education. At some point along the continuum of care, a screen for pain occurs in all patients in our organization. When warranted by the screen, patients undergo a comprehensive pain assessment by the primary care provider or a consult is made to the appropriate specialty by the provider.

3. SCOPE: Pain management involves the efforts of all clinical staff members assigned to Raymond W. Bliss Army Health Center (RWBAHC) who have contact with patients.

4. REFERENCES: The Joint Commission Comprehensive Accreditation Manual for Ambulatory Care, current edition

*This memorandum supersedes MEDDAC MEMO 40-163, dated 20 OCT 04.

5. RESPONSIBILITIES

5.1 The Deputy Commander for Clinical Services (DCCS) will:

5.1.1 Serve as the proponent for this memo and ensure that the standards defined in this memo are enforced in all patient care areas.

5.1.2 Ensure education on pain management is provided to all clinical staff on an annual basis.

5.2 The Deputy Commander for Health Services (DCHS) will ensure initial and annual competency based assessment of all clinical support staff and assist in the enforcement of pain management standards in all patient care areas.

5.3 Department/Service Chiefs will:

5.3.1 Ensure department/service staff comply with the standards defined in this memorandum.

5.3.2 Ensure copies of patient Bill of Rights, which states that all patients have the right to appropriate pain management, is prominently displayed in the clinics.

5.4 Licensed Independent Practitioners(LIP) will:

5.4.1 Perform comprehensive assessments of patients with pain when indicated.

5.4.2 Prescribe appropriate analgesics and/or adjuvants.

5.4.3 Document assessment/findings/education in the patient's chart.

5.4.4 Consult other services within the organization as necessary to facilitate a multi-disciplinary approach to pain management.

5.4.5 Refer patient to another medical treatment facility when the complexity of a patient's pain management exceeds individual expertise or involves modalities not available at RWBAHC.

5.5 Registered or Licensed Practical Nurses will:

5.5.1 Ensure that Medics (68W)/Certified Nursing Assistants under their supervision apply and document age-specific pain screening criteria when warranted by the chief complaint.

5.5.2 Administer medications as prescribed by providers in accordance with RWBAHC policies, MEDCOM, and National Nursing Practice Standards.

5.5.3 Educate patient/family members at the site of care about pain management.

5.6 Medics (68W)/Certified Nursing Assistants will: Apply and document age-specific pain screening criteria when warranted by the chief complaint.

5.7 The pharmacy staff will verify that any patient receiving an analgesic prescription has been given appropriate written information regarding their medication - to include side effects and any food/drug interactions.

6. PAIN MANAGEMENT PHILOSOPHY. The organization recognizes that pain is an extremely subjective experience and as such, the patient is the best judge of the intensity of pain. If the patient is unable to report, other methods to assess pain include:

6.1 Family or others close to the patient reports of pain;

6.2 Patient behavior;

6.3 Physiological parameters.

7. SCREENING. The organization conducts pain screening in a uniform fashion by using standardized tools. A standard pain screen for the presence, intensity, and location is documented in the electronic medical record (AHLTA). Details concerning how the organization screens for pain intensity are covered at Appendix A. Exceptions to the above would include the Optometry Clinic and the Department of Anesthesia and Perioperative Services (DAPS). Optometry documents the pain assessment on RWBAHC OP 79-1 and DAPS notes pain on different forms throughout the process.

7.1 All patients of RWBAHC will be assessed for pain at each visit. In special circumstances where a patient is seen for multiple visits for the same symptom of pain (i.e. back pain), the pain screening will be per the discretion of the LIP and documented as appropriate.

8. ASSESSMENT: A positive screen for pain triggers a comprehensive assessment in the patient care area where the screen occurs or a referral to the appropriate service. A LIP will perform the assessment. When conducted, an adequate assessment will consider addressing the six elements of pain for example:

8.1 Clarification of intensity

8.2 Clarification of location

8.3 Clarification of duration

8.4 Characteristics of the pain (aching, burning, shooting, etc.)

8.5 Frequency

8.6 Aggravating/alleviating factors

9. PAIN MANAGEMENT:

9.1 Licensed Independent Practitioners (LIPs) working in the Department of Primary Care, the Department of Military Medicine clinics and Specialty Clinics perform limited pain management in patients with straightforward pain conditions as delineated per the provider's credentials. Examples of modalities that may be used include the administration or prescribing of analgesics/adjutants, the application of ice packs, soft tissue steroid injections, or the splinting of fractures.

9.2 LIPs working in the Department of Behavioral Health clinics may perform or assist with limited management of pain in patients with straightforward pain conditions - especially when the pain symptom has a major psychological component. Modalities used include the administration or prescribing of analgesics or adjuvants.

9.3 The extent of pain management performed in the Department of Specialty Services (General Surgery, Optometry, Orthopedics and Physical Therapy Clinics) will be within the provider's scope of practice and dependent on the provider's credentials. Documenting of the pain and treatment will be per the clinic's established protocols.

9.4 Providers in the Preventive Medicine Wellness and Readiness Service refer patients with positive pain screens to the Department of Primary Care or the Department of Military Medicine as appropriate for further pain assessment and management.

9.5 Patients with complex pain management needs that require extensive ongoing education and counseling, complex oral pain regimens, invasive pain management techniques, or other modalities that fall outside the organization's scope - patients who do not respond to standard pain control modalities offered by our providers - are referred to pain management specialists either at military medical centers or to specialists in the TRICARE Network.

9.6 The Department of Anesthesia & Perioperative Services will manage acute pain consistent with a patient's perioperative course. A surgical pain intensity report by the patient of less than six on a scale of one-ten (one, almost no pain at all and ten, maximum pain) immediately after surgery is the goal for pain control during recovery and prior to discharge from the PACU. The Department of Anesthesia is not available for referrals for chronic pain management.

10. PATIENT AND FAMILY EDUCATION:

10.1 At the site of care, providers and registered/licensed nursing staff share a responsibility to teach patients and their family/significant other(s) that pain management is part of their treatment. Healthcare providers and nursing staff will consider personal, cultural, spiritual and ethnic beliefs, communicating to patients and families the importance of pain management.

10.2 Education content includes, but is not limited to:

10.2.1 Types of pain the patient actually or potentially experiences.

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10.2.2 Pain control mechanisms available and/or that have been employed to include non-pharmacological therapy: exercise programs, acupuncture, TENS(Transcutaneous Electrical Nerve Stimulation) therapy, heat/cold massage and physical therapy.

10.2.3 Potential limitations of pain management and treatment;

10.2.4 Potential and/or actual side effects of pain management and treatment;

10.2.5 Determination of the patient's acceptable level of pain.

10.3 Directions and precautions for preparation, self-administration, and home use of medications. Side effects or drug interactions should also be discussed.

11. PERFORMANCE IMPROVEMENT. The Provision of Care Function Management Team will analyze data from a representative sample of reviewed medical records across the organization. Conclusions and recommendations from this committee will be forwarded to the Executive Committee of Professional Staff (ECOPS) as needed to continually assess and improve the organization's pain management responsibilities.

The proponent of this publication is Deputy Commander for Clinical Services. Users are invited to send comments and suggested improvements on DA Form 2028 directly to DCCS, ATTN: MCXJ-DCCS, USA MEDDAC, Ft Huachuca, AZ 85613-7040

FOR THE COMMANDER:

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APPENDIX A**Screening for PAIN INTENSITY SCALES AUTHORIZED FOR USE
Whaley/Wong Pain Faces and 0-10 Pain Scale (Color)**

Children: The adapted 0-10 Wong-Baker Faces Pain Scale will be used if the children are able to report their pain. The Post Anesthesia Care Unit will correlate their Wong -Baker Faces Scale with a numeric designation utilizing the 0-10 Numeric Scale Children are presented with face drawings representing the happiest feeling possible to the saddest feeling possible.

Adult: The 0-10 Numeric Scale will be used for adult patients. The number reported by the patient is the "pain score" and will be documented.

**Appendix B
MEDCOM FORM 686-R**

MEDICAL RECORD - SHORT STAY ASSESSMENT <small>For use of this form, see MEDCOM Circular 40-5</small>	
DIRECTIONS: This assessment is for use with the adult patient whose hospital stay is less than 24 hours. It should be completed by the RN, or other health care personnel according to local policy.	
SECTION I: VITAL SIGNS/OTHER INFORMATION	
Date: _____ Time: _____ Patient oriented to: <input type="checkbox"/> Safety procedures <input type="checkbox"/> Call light use <input type="checkbox"/> Side rail use <input type="checkbox"/> Unit procedures Temp: _____ <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Axillary <input type="checkbox"/> Tympanic Pulse: _____ Respirations: _____ BP: _____ Rhythm: _____ Height: _____ Weight: _____ Presenting Complaint: _____ Allergies: _____	
SECTION II: REVIEW OF SYSTEMS Directions: A check (✓) in the small box, left column, indicates stated description reflects actual physical findings. An asterisk (*) in the box indicates that a variance exists. A brief explanation of abnormal findings is required, or you may circle the appropriate descriptive terms.	
1. NEUROLOGICAL. Alert and oriented to time, place, self, and situation. Responds appropriately. Communication is adequate to express needs. Pupils equal bilaterally and reactive to light. Grip strength equal.	Lethargic Unresponsive Comatose Agitated Disoriented Aphasic Doesn't speak/understand English
2. CARDIOVASCULAR. Pulse regular, rate within normal range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. No clubbing. No chest discomfort. Capillary refill is ≤ 2 seconds.	Arrhythmia _____ Tachycardia Bradycardia Pitting edema Cyanosis Capillary refill = _____ seconds. Pacemaker (Type): _____
3. PULMONARY. Respirations quiet and regular, rate within normal range for age. Depth is regular. No cough or shortness of breath. Lungs clear to auscultation, all lobes. Chest movement is symmetrical.	Cough: Productive/non-productive Hemoptysis Orthopnea Dyspnea Wheezing Rales/rhonchi Night sweats
4. G.I. Oral mucosa moist; no lesions or bleeding gums noted. Dental hygiene adequate. Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies diarrhea, constipation, or rectal bleeding. Denies recurrent laxative use. No change in appetite.	Halitosis Nausea Vomiting Incontinence Diarrhea Constipation Hemorrhoids Rectal bleeding Heartburn Distension Flatus Last BM: _____ Bowel frequency: _____ Ostomy: _____
5. G.U./REPRODUCTIVE. Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual vaginal/penile/breast discharge. No genital lesions; no breast/testicular lumps. No history (hx) of STD exposure/disease.	Hematuria Retention Frequency Incontinence Nocturia Catheter: Foley/External/Supra-pubic Hx of UTI/calculi Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain LMP: _____
6. MUSCULOSKELETAL. Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal ROM without pain. No joint stiffness, swelling/tenderness, weakness, or paresthesia. No hx of DVT or (+) Homan's sign.	Amputation: _____ Assistive devices: _____ Weakness/paralysis: _____ Homan's sign (L) / (R) leg
7. SKIN. Warm, dry, intact. Normal turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist and intact.	Cyanotic Cold Diaphoretic Flushed Pale Jaundiced Poor turgor
8. PSYCHOSOCIAL. Behavior is appropriate to the present situation. Anxiety is controlled or mild and appropriate. Interacts appropriately with others.	Anxious Fretful Tearful Withdrawn Angry Apprehensive
9. SLEEP. Sleep is usually restful; awakes refreshed.	Patient's description of sleep: _____ Assistance needed to fall asleep: _____
10. PAIN. No current complaint of pain/discomfort. No ongoing (chronic) pain problems.	PAIN ASSESSMENT. For patients complaining of pain, complete the following: Intensity of Pain Scale: (0 = No pain; 10 = Worst pain)
PATIENT IDENTIFICATION (For typed/written entries note: Name - last, first, middle initial; grade; DOB; hospital/MTF)	Location(s): _____ Intensity/Description: _____ Onset/Duration: _____ Exacerbated by: _____ Alleviated by: _____

SECTION III: EDUCATIONAL ASSESSMENT		
Does the patient exhibit a readiness to learn? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain: _____		
What is his/her most effective method of learning? <input type="checkbox"/> Reading <input type="checkbox"/> Listening <input type="checkbox"/> Pictures <input type="checkbox"/> Demonstration		
<input type="checkbox"/> One-on-One <input type="checkbox"/> Group/classroom instruction		
Education/grade level achieved? <input type="checkbox"/> 0-8 years <input type="checkbox"/> 9-12 years <input type="checkbox"/> 13-16 years <input type="checkbox"/> 15 + years		
TEACHING NEEDS: Identify specific areas for patient/family education. <i>(Check all that apply)</i>		
<input type="checkbox"/> Advance directives	<input type="checkbox"/> Infection control	<input type="checkbox"/> Respiratory care
<input type="checkbox"/> Breast/testicular self exam	<input type="checkbox"/> Isolation precautions	<input type="checkbox"/> Safety precautions
<input type="checkbox"/> Community resources	<input type="checkbox"/> Medical equipment use	<input type="checkbox"/> Sexual concerns
<input type="checkbox"/> Drug-food interaction	<input type="checkbox"/> Medications	<input type="checkbox"/> Skin care/hygiene/grooming
<input type="checkbox"/> Elimination	<input type="checkbox"/> Nutrition/hydration	<input type="checkbox"/> Stress management
<input type="checkbox"/> ETOH/tobacco/drug use/abuse	<input type="checkbox"/> Pain management	<input type="checkbox"/> Other <i>(Specify):</i> _____
<input type="checkbox"/> Health promotion	<input type="checkbox"/> Procedure/treatment	
<input type="checkbox"/> Illness/diagnosis	<input type="checkbox"/> Rehabilitation techniques	
Factors which may influence the patient's ability to learn:		
<input type="checkbox"/> Cognitive limitations	<input type="checkbox"/> Language barrier	<input type="checkbox"/> Psychological factors
<input type="checkbox"/> Cultural/religious factors	<input type="checkbox"/> Motivation	<input type="checkbox"/> Sensory limitations
<input type="checkbox"/> None - Patient verbalizes/demonstrates understanding.		<input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Vision
Does the patient want educational materials? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(Specify below)</i>		
COMMENTS: _____		

SECTION IV: FUNCTIONAL ASSESSMENT (Bathing, dressing, grooming, toileting, mobility, etc.)		
<input type="checkbox"/> The patient demonstrates no functional limitations.		
<input type="checkbox"/> Problem noted: _____		
SECTION V: NUTRITION ASSESSMENT (Weight loss/gain, nausea/vomiting, appetite changes, eating disorder, etc.)		
<input type="checkbox"/> WNL - No problem w/food or fluids. <input type="checkbox"/> Special diet/restrictions: _____		
<input type="checkbox"/> Problem noted: _____		
SECTION VI: SPIRITUAL AND SOCIAL NEEDS		
Is there anything we can do to meet your spiritual or cultural needs while you are in the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," please explain: _____		
Do you have other concerns that we can help you with? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," please explain: _____		
SECTION VII: DISCHARGE PLANNING ASSESSMENT - Based on the data collected, it appears the patient will: <i>(Check all that apply)</i>		
<input type="checkbox"/> Have no difficulty returning to home environment - no referrals required.	Discharge is anticipated to: <input type="checkbox"/> Home alone	
<input type="checkbox"/> Require assistance in making transition to home - initiated referral to the following:	<input type="checkbox"/> Home w/family	
<input type="checkbox"/> Home Health <input type="checkbox"/> Social Work <input type="checkbox"/> Case Manager <input type="checkbox"/> Other: _____	<input type="checkbox"/> Barracks	
<input type="checkbox"/> Family/significant other able to care for/meet patient needs.		
OTHER CONTINUITY OF CARE ISSUES: _____		
Patient's Advance Directive (Living Will, Durable Power of Attorney for health care) is current and included in the medical record?		
<input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," explain: _____		
From this initial assessment, note patient problems/needs on MEDCOM Form 687-R (Test), Interdisciplinary Plan of Care and/or MEDCOM Form 691-R (Test), Patient Release/Discharge Instructions.		
Assessed by: _____		
(Signature)	(Printed Name & Title)	(Date)

