UWMC Medical Staff Inpatient Acute Pain Management Policy & Procedure

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Purpose:
1. Define acute pain management
2. Outline Hospital policy regarding inpatient acute pain management.
3. Emphasize the patient’s right to appropriate and adequate pain management.
4. Establish boundaries for safe and effective pain management provided by credentialed medical providers for patients except for those in the Neonatal Intensive Care Unit.
5. Clarify pain management within context of UWP global surgical package.
6. Provide guidelines for pain service consultation and treatment

Policy:
The reduction of pain and suffering is integral to UWMC’s mission of providing the highest quality of service to our patients. Patients have a right to appropriate pain assessment and management such that adequate function is preserved (see Appendix II, Patients’ Pain Bill of Rights). Adequate pain management is associated with improved quality of life and patient satisfaction. Various modalities may be selected to treat pain. Treatment of pain may be associated with side effects and drug interactions some of which are potentially life threatening. Patient safety and comfort are priorities in pain management.

Procedures:
1. Modalities Used for Inpatient Acute Pain Management (Appendix III):
   a. Systemic/Parenteral-administered Opioid
      i. Accepted Uses:
         — Opioids are effective for the management of moderate to severe intensity acute pain.
         — For severe or uncontrolled pain, parenteral (i.v. or subcutaneous) routes are recommended.
      ii. Restrictions:
         — In patients whose pain continues or is not likely to resolve quickly, patient controlled analgesia should be considered.
         — Concomitant use of other CNS depressant drugs should be avoided, at least until the effect of the opioid administered is deemed safe and appropriate and not likely to result in excessive sedation or respiratory depression.
         — Transdermal/transmucosal fentanyl is not recommended for routine use in management of acute or postoperative pain.
         — Typically, one route of administration with one type of opioid should be used at any one time.
b. Patient-controlled Analgesia (PCA)
   i. Accepted Uses:
      — PCA is the preferred modality for ongoing parenteral opioid administration.
      — Patients are candidates for PCA if they have the cognitive, physical, and psychological ability to manage their pain.
      — All credentialed medical providers are permitted to order opioid by PCA.
      — Routine use of PCA will be at the discretion of the Primary Surgical/Medical Service and for surgery is part of the global surgical package; consultation with the Pain Service is not required.
   ii. Restrictions (PCA use not appropriate without Pain Service consultation):
      — Patients who are intermittently or frequently drowsy or confused or who are impaired from other CNS depressant drugs should be considered to be at risk for potentially serious complications (including death) from PCA use.
      — PCA by Proxy is prohibited.
      — Primary Service providers (excluding Pain Service and Hemopoietic Stem Cell Transplant/Oncology providers) may only prescribe PCA opioids as defined in form #UH0774. Doses on this form may not be exceeded.
      — Form #UH0840 may only be prescribed by the Pain Service.
      — Form #UH1318 may only be prescribed by Pain Service and Hemopoietic Stem Cell Transplant/Oncology providers).
      — If doses on PCA form #UH0774 are exceeded, a formal consultation with the Pain Service is required to facilitate pain management for opioid use that exceeds expected standard limits. (Appendix III, 2 (iv))

c. Neuraxial/epidural Analgesia (Appendix V)
   i. Accepted Uses:
      — Epidural analgesia enables the segmental administration of analgesics neuraxially thus improving our ability to improve pain relief for appropriate conditions such as surgical procedures (see below).
      — Placement of neuraxial/epidural catheters is an anesthesia procedure.
— Selection of patients for neuraxial/epidural catheter placement will be at the discretion of the attending anesthesiologist or Pain Service in collaboration with Surgical Service.
— A formal surgical consultation is not required for placement.

ii. Restrictions:
— A potentially serious complication from epidural catheter use is epidural hematoma particularly if drugs are used concomitantly that may impair coagulation (e.g., low molecular weight heparin, therapeutic doses of standard heparin, and antiplatelet agents).

d. Peripheral nerve block
i. Accepted Uses:
— Single-shot injections or catheters are used to provide prolonged regional anesthesia/analgesia in selected patients.

ii. Restrictions:
— Potentially serious complications can occur if drugs are used concomitantly that may impair coagulation (e.g., low molecular weight heparin, therapeutic doses of standard heparin, and antiplatelet agents).

e. Local Anesthetic Wound Infusions
i. Accepted Uses:
— As an adjunct to other modalities used for Inpatient Acute Pain Management as listed above.

ii. Restrictions:
— As defined under Appendix VIII.

2. Recognition of opioid-induced respiratory depression (See Appendix IV)
3. Role of the Pain Service
   a. The Primary Service will be responsible for the safe administration of parenteral opioid therapy by PCA as defined under Patient-Controlled Analgesia, section 1(b) above. Exceptions to this will be at the discretion of the Pain Service.
   b. Epidural/neuraxial analgesia for acute pain management will be provided solely by the Pain Service.
   c. The Pain Service will be available for consultation of diagnostic issues related to pain management.
   d. Ongoing pain management will be a combined collaboration between the Pain Service and the Primary Service.
   e. If appropriate, the Pain Service will assume aspect of care for individual pain management issues. If the consult service agrees to accept responsibility for pain management, this should be noted by a written order from the consult service and should be documented in a progress note from the primary service, as described in UWMC’s Consultation Guidelines.
f. A formal pain consultation with the Pain Service is not required for postoperative pain management for high-risk patients (Appendix Iv c(v)) who in the opinion of the attending anesthesiologist merits preemptive analgesic care.

g. Documentation of medical necessity for postoperative pain management in the high-risk patient by the Pain Service will be made by the anesthesiology attending or Pain Service attending taking care of the patient; formal surgical consultation is not required in this situation.

Review Date:
APPENDIX:

I. Definitions:

a. **Acute pain** is the perception of pain associated with noxious stimuli (tissue injury or tissue trauma). Typically, pain moderate to severe in intensity, is associated with a known precipitator, and is of short duration. Examples of acute pain include post surgical pain, medical conditions (sickle cell crisis, acute pancreatitis, myocardial infarction, acute/subacute bowel obstruction, acute exacerbation of inflammatory bowel disease, acute flare of rheumatologic conditions, etc.), labor/post delivery pain, sports injuries, etc.

b. **Chronic Pain** is persistent pain following expected healing time. The principles of treatment for chronic pain are different from acute pain.

c. **Patient Controlled Analgesia**: An interactive method of pain management that permits patients to manage their pain by self-administrating doses of analgesics usually opioids.

d. **Opioid Naïve**: Patients who are not currently taking opioids or who have not taken opioids for at least 1 week in the previous 3 month period.

e. **Opioid Tolerance**: Tolerance is a physiological state characterized by a decrease in the effects of a drug (e.g., analgesia, nausea or sedation) with chronic administration. Opioid tolerance is a function of both dose and duration of use and can develop quickly even with intraoperative opioid use, or it can develop after a few days or weeks of regular use. Depending on dose and length of exposure, opioid-tolerant patients require significantly higher and more frequent doses of perioperative opioids for adequate pain control.

f. **UWP Global Surgical Package**: UWP defines and bills for services during the global surgical period in accordance with CMS guidelines. UWP policies reflect a single standard of documentation of care for services provided, which UWP will bill according to payer specific requirements. While not required, to demonstrate the medical necessity of concurrent care by the second physician, it is desirable that the UWP surgeon document his or her request for another physician to manage an aspect of the patient’s condition during the post-operative period. This will include the need for perioperative pain management for high-risk inpatients (see below), patients whose opioid requirements exceed standard PCA requirements by Primary Service (see below), and patients who may benefit from neuraxial/epidural pain relief. A pain consultation is not mandated in these scenarios. In such cases, decisions regarding postoperative pain management will be at the discretion of the attending anesthesiologist or Pain Service in collaboration with the Surgical Service and will be documented for medical necessity by the anesthesiologist.

g. **Credentialed Medical Provider**: Privileges approved by UWMC Credentialing Committee.

II. Patients’ Pain Bill of Rights:

a. The patient’s right to pain management is established at UWMC in Patient’s Bill of Rights education booklet. Patients have the right to
effective pain management. Pain will be assessed and managed as deemed medically appropriate. The essential principles include:

i. The right to have pain complaint believed by all involved in care
ii. That pain will be checked on a regular basis and dealt with quickly.

b. Patient responsibilities will include:
   i. Asking about pain relief options
   ii. Describing and rating pain
   iii. Asking for medication when pain first begins
   iv. Informing if the medicine or treatment worked.

III. Modalities Used For Acute Pain Management:
   1. Systemic/Parenteral-administered Opioid:
      i. Frequent low doses of i.v. opioids (e.g., morphine 2-4 mg, hydromorphone 0.4-0.8 mg; for opioid naive patients, recommend lower doses initially) q5-10 minutes with reassessment of response between doses should be considered especially for opioid naïve patients.
      ii. Concomitant use of other CNS depressant drugs should be avoided, at least until the effect of the opioid administered is deemed safe and appropriate and not likely to result in excessive sedation or respiratory depression. Examples of CNS depressant drugs include benzodiazepines; antiemetics such as compazine, phenergan; sedative /hypnotics; barbiturates; antihistamines.
      iii. Using more than one opioid and route of administration to manage pain is confusing, costly and usually unnecessary.
      iv. Intramuscular administration of opioids should be considered an inefficient method to deliver opioids systemically and use of this route is not encouraged.
      v. Methadone is a potent opioid analgesic with complex pharmacokinetic and pharmacodynamic properties. Routine administration of methadone is not recommended for patients who will continue on i.v. opioids by PCA or who receive neuraxial opioids. UWM has adopted a policy on the intraoperative use of i.v. methadone (September 2002).
      vi. Providers must ensure safe administration of systemic opioids.

   2. Patient-Controlled Analgesia:
      i. In general, opioid administration by this modality is considered safe, effective, and appropriate in an inpatient setting where patients are appropriately monitored.
      ii. PCA by Proxy is never allowed: Patient and family/significant others will be educated on PCA therapy and instructed that the patient and only the patient is allowed to press the button for pain medication.
      iii. Providers must ensure safe administration of PCA opioids.
      iv. In order to maintain safe medical practice, limitations to PCA prescription are necessary. Exceptions to this will be at the
discretion of the Pain Service. However, once doses on PCA form #UH0774 are exceeded, a formal consultation with the Pain Service is required to facilitate pain management for opioid use that exceeds expected standard limits. Examples of clinical scenarios where this may happen include:

1. Postoperative patients whose opioid requirements exceed standard PCA settings as listed on form #UH0774
2. Medical patients whose opioid requirements exceed standard PCA settings as listed on form #UH0774

v. Inadequate pain relief and/or an increasing trend in sedation (patients are frequently drowsy, but easy to arouse, patient unable to complete a sentence without falling asleep) may require a re-evaluation of the appropriateness of PCA use and prompt consultation with the Pain Service.

vi. A list of procedures, surgical incisions, and patient conditions that would qualify for pre-emptive analgesia will be developed in collaboration between surgery and anesthesiology.

3. Neuraxial/Epidural Analgesia:
   i. This modality may facilitate early patient mobilization (e.g., after large incisions), initiation of physical therapy (e.g., after bone/joint therapy), and/or enhanced ventilatory function (e.g., after thoracic surgery).
   ii. Placement of neuraxial/epidural catheters is a specialized technique performed by a credentialed medical provider using appropriate sterile technique.
   iii. Commonly used drugs for epidural administration include local anesthetics (e.g., bupivacaine) and opioids (e.g., morphine or fentanyl).
   iv. Successful use of local anesthetics in the epidural space requires an appropriately placed catheter for the surgical incision.
   v. The intent of epidural local anesthetic administration is to provide segmental analgesia or anesthesia for that surgical incision.
   vi. Common side effects associated with the use of local anesthetics in this fashion include hypotension particularly in patients who are relatively or absolutely hypovolemic. Thoracic epidural local anesthetic administration typically do not impair bladder or bowel function.
   vii. Neuraxial administration (epidural or intrathecal) opioid administration may have prolonged effects (12-24 hours). Patients who receive this modality should be considered at risk for opioid-induced respiratory depression during this interval. Concomitant use of other CNS depressant drugs may increase the risk of opioid-induced respiratory depression.
   viii. The decision to discontinue epidural analgesia in post-operative patients will include senior level communication between the Pain Service and the primary surgical team. The goal is to balance the
safety and pace of recovery, through increased ambulation and discharge planning, with the principles of pain relief as outlined in the Patients' Pain Bill of Rights.

ix. The factors involved in selection will follow the guidelines listed below (Appendix V).

4. Peripheral Nerve Block
   i. Maintenance and discontinuation of this modality will be at the discretion of the Pain Service.

IV. Opioid-Induced Respiratory Depression:
   a. Opioid-induced respiratory depression is defined as persistent sedation in a patient not easily aroused after systemic or parenteral opioid administration in the presence of low respiratory rate (< 8 bpm) or with a PaCO2 > 50 mm Hg.
   b. Persistent opioid-induced respiratory depression should be considered a life threatening event.
   c. Risk factors for such events include:
      i. Concomitant use of CNS depressant drugs
      ii. Inappropriate dose selection of PCA settings
      iii. Rapid titration and escalation of opioid doses
      iv. Extensive surgical procedures resulting in pain that is refractory to systemic opioid therapy (see below)
      v. Patient risk factors:
         — Morbid obesity (BMI > 40)
         — History of obstructive sleep apnea
         — Upper airway compromise
         — Intolerance or sensitivity to opioids
         — Opioid tolerance
         — Ongoing or history of substance abuse
         — Current or recent history of alcohol abuse
         — Elderly
         — Prior history of opioid-induced respiratory event
         — Low pain tolerance

V. Factors involved in selection of Epidural Analgesia:
   a. The primary goal of epidural analgesia is to provide segmental analgesia thus avoiding systemic opioid-related side effects and facilitating functional activities and as such significantly differs from PCA opioid administration.
   b. As the nature of surgical and anesthesia procedures change, the following should not be considered a complete list and additions or exceptions may be required in the future. Current examples of surgical procedures appropriate for segmental analgesia include:
      i. Thoracotomy (e.g., lobectomy, lung volume reduction surgery, pneumonectomy, etc)
      ii. Upper abdominal procedures with a transverse or vertical incision (e.g., exploratory laparotomy, whipple procedure, open cholecystectomy, partial gastrectomy, small bowel resection, etc).
iii. Upper and lower abdominal procedures (e.g., abdominal aneurysm repair, exploratory laparotomy, retroperitoneal tumor resection, radical nephrectomy, etc.).
iv. Lower abdominal/pelvic procedures with a midline incision extending at least to the umbilicus (e.g., colectomy, total abdominal hysterectomy, cystectomy, retroperitoneal lymph node dissection, etc).
v. Retroperitoneal procedures with a flank incision (e.g., nephrectomy).
vi. Lower extremity procedures with major bone resection/reconstruction (e.g., radical tumor resection, total knee arthroplasty, etc).

c. Patient specific:
   i. Patient request
   ii. Opioid tolerance resulting from chronic opioid use
   iii. Use of opioids that would likely result in development of opioid-induced respiratory depression (patient sensitivity, prior history of opioid-induced respiratory depression/sedation, rapid escalation in opioid dose in the early postoperative period)
iv. Failure to adequately relieve pain with conventional opioid use in a timely fashion in the early postoperative period.
   — Persistent pain with poor functional goals (e.g. inadequate cough, inability to mobilize due to pain, poor incentive spirometry use due to pain)
   — Intractable opioid-related side effects (e.g. nausea, vomiting, constipation, sedation, cognitive impairment)

VI. PCA PHYSICIAN ORDERS:
a. These forms are UH0774, UH0840, and UH1318.
b. These forms are subject to change and providers are required to follow the latest update.

VII. EPIDURAL/INTRATHECAL ANALGESIA PHYSICIAN ORDERS
a. This form is UH0949
b. This form is subject to change and providers are required to follow the latest update.

VIII. PERIPHERAL NERVE/WOUND INFUSION PUMP ORDERS
a. This form is UH2245
b. This form is subject to change and providers are required to follow the latest update.

Reviewed: