

Acute Pain Management of Adults in the Post Anaesthetic Care Unit:

Intravenous Opioid Pain Protocol Learning Package

Participant Name:

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Section One

Introduction:

The most widely recognised definition of pain is that of the International Association for the Study of Pain: “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage” (Shchug et al. 2015); although, there is simpler, alternative working definition of pain, devised by McCaffery (1968) that remains the gold standard in pain assessment today: **“pain is what the experiencing person says it is, existing whenever he says it does.”**

Pain continues to be one of the most prevalent reasons for patients to seek medical attention and an anticipated complication of surgical intervention (Odom- Forren, 2013). The importance of treating pain adequately cannot be underestimated. Early and effective management of postoperative pain is important for many reasons, including the minimisation of discomfort, promotion of optimal recovery, and the facilitation of early mobilisation. Properly treated pain can also reduce the incidence of pain related complications, including pulmonary deteriorations (i.e. atelectasis), psychological distress and the transition of acute pain to chronic pain syndromes (Odom- Forren 2013).

In the post anaesthetic care unit (PACU) environment, one of the major focuses and responsibilities of nursing care is the immediate acute pain management of postoperative patients (ACORN 2014). In order to provide optimal patient care, it is essential that the PACU nurse have the necessary knowledge, skills and attitudes to administer pain relief in a safe and timely manner. The PACU nurse must use the analgesic resources available to him/her to provide effective and evidence based methods of pain relief (ACORN 2014).

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It is important to note that opioids are considered schedule 8 drugs according to the “Poisons and Therapeutic Goods Act” (2012); therefore all drugs prepared and administered for pain protocol must be done so in accordance with the “Medication Handling in NSW Public Health Facilities” (2013) policy directive, and in accordance with the local clinical business rules in your facility.

Purpose:

The purpose of this learning package is to provide nurses working in PACU areas across the SESLHD with the theory and knowledge necessary to inform their practice of administering intravenous opioid pain protocol. Using evidence based principles, these resources will provide essential information about this advanced skill and seek to provide nurses with the tools necessary to provide safe, effective and patient centered care in a timely manner. Assessment of learning will be made through a quiz and assessment of practice using a checklist and modified Bondy scale.

Aim:

The aim of this learning package is to support safe nursing practice in the administration of intravenous opioids in the PACU environment. This resource seeks to enhance nurse’s knowledge and practice relating to pain and safe pain assessment and management to surgical patients in the immediate postoperative time frame.

Learning outcome statements:

Upon completion of this learning package, the PACU nurse should be able to:

1. Describe pain assessment and the methods used to measure the pain of both communicative and non-communicative and non-English speaking background (NESB) patients.

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2. Discuss the four opioids (fentanyl, hydromorphone, morphine and oxycodone) used for pain protocol in terms of their onset, peak and duration of effect.
3. Describe the side effects and complications of opioids.
4. Describe the management of severe respiratory depression and sedation, and the management of such complications.
5. State the action of naloxone, its indication(s) and its administration according to respiratory depression, post-operative nausea and vomiting (PONV) and pruritus.
6. Describe how the patient's age, pain assessment and vital signs influence opioid dosage.
7. Demonstrate the safe preparation, administration, titration and discarding of opioids in accordance with the pain protocol

Resources:

ACORN. 2014/15. Nursing Role: Postanaesthesia Recovery (PAR) Nurse. Adelaide.

McCaffery, M 1968, *Nursing practice theories related to cognition, bodily pain and man-environment interactions*, Los Angeles, University of California.

Odom-Forren, J. 2013. *Drain's Perianaesthesia Nursing: a critical care approach*. 6th (eds). St. Louis: Missouri, Elsevier- Saunders.

POWH. 2011. Naloxone Administration for Opioid Induced Respiratory Depression.

POWH. 2015. Pain Assessment and Measurement Guidelines.

Schug SA, Palmer GM, Scott DA, Halliwell R, Trinca J; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine

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(2015), Acute Pain Management: Scientific Evidence (4th edition), ANZCA and FPM, Melbourne.

SESLHD. 2016. Acute Pain Management in the Post Anaesthetic Care Unit: Fentanyl, HYDRomorphone, Morphine & Oxycodone.

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Section Two

Definitions:

- **Aliquot:** Measured part of a whole volume
- **Multimodal Analgesia:** combining drugs with different underlying mechanisms of action, with the intention of using lower doses of each, and reducing the risk of adverse effects.
- **SESLHD:** South Eastern Sydney Local Health District
- **Therapeutic ratio:** refers to the relationship between toxic and therapeutic doses. It is important in clinical practice because it determines how safe (or toxic) a drug is.
- **Titration:** Opioid titration refers to the adjustment of the dosage of an opioid, according to effect, respiratory rate and sedation score; given in small amounts at a time.

Pain Assessment:

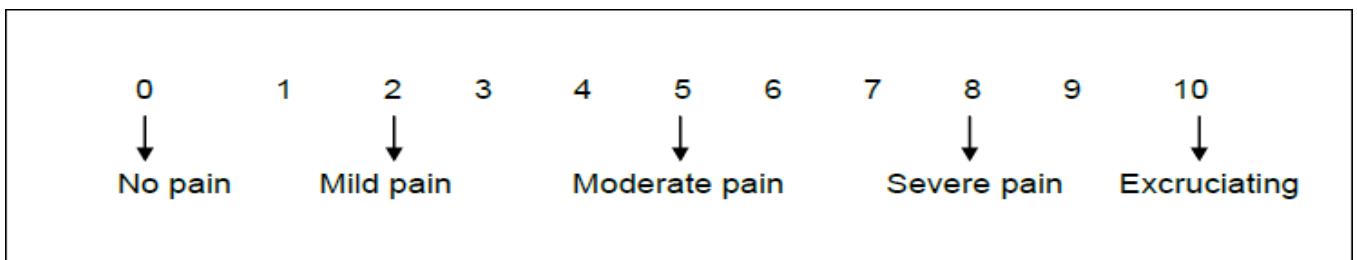
Pain assessment is an essential and specialised skill of nurses in the PACU environment. Having the skills, knowledge and attitudes necessary to monitor, observe and make meaning of behaviors indicative of pain and discomfort is an important part of providing patient centered care (ACORN 2014).

It is well recognised that patient self-reporting is the gold standard in pain assessment (Schug et al, 2015). However, when a patient is unable to communicate their pain through verbal numerical and descriptor scales, they are at a higher risk of having under treated pain (Odom-Forren 2013). There are tools available to assess pain in such patients including, the Faces Pain Scale- Revised (FPR), and the PAINAD (POWH 2015).

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The above mentioned pain measurement tools are provided below. Please refer to your local pain assessment guidelines for further information.

Verbal Numerical and Descriptor Scales



(POWH CBR. 2015. Pain Assessment and Measurement Guidelines).

Faces Pain Scale - Revised



(Copyright of the FPS-R is held by the International Association for the Study of Pain (IASP) ©2001).

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Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	<ul style="list-style-type: none"> Normal 	<ul style="list-style-type: none"> Occasional labored breathing Short period of hyperventilation 	<ul style="list-style-type: none"> Noisy labored breathing Long period of hyperventilation Cheyne-Stokes respirations 	
Negative vocalization	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Occasional moan or groan Low-level speech with a negative or disapproving quality 	<ul style="list-style-type: none"> Repeated troubled calling out Loud moaning or groaning Crying 	
Facial expression	<ul style="list-style-type: none"> Smiling or inexpressive 	<ul style="list-style-type: none"> Sad Frightened Frown 	<ul style="list-style-type: none"> Facial grimacing 	
Body language	<ul style="list-style-type: none"> Relaxed 	<ul style="list-style-type: none"> Tense Distressed pacing Fidgeting 	<ul style="list-style-type: none"> Rigid Fists clenched Knees pulled up Pulling or pushing away Striking out 	
Consolability	<ul style="list-style-type: none"> No need to console 	<ul style="list-style-type: none"> Distracted or reassured by voice or touch 	<ul style="list-style-type: none"> Unable to console, distract, or reassure 	
TOTAL SCORE				

(Warden et al., 2003)

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

(POWH CBR. 2015. Pain Assessment and Measurement Guidelines).

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All patients have the basic right to receive adequate amounts of pain relief. Using the appropriate pain scales for the individual patient, allows for optimal and the most successful management of pain in all patients regardless of their ability to express themselves verbally. Odom- Forren (2013, p. 435) refers to a hierarchy of pain measures.

1. **Patient's self-report.** This is by far the most effective tool in pain assessment and measurement and this method should be employed and relied upon wherever possible.
2. Consider pathological conditions that may cause pain or exposure to painful stimuli (ie, surgical or procedural intervention). *Do you expect the patient to experience pain?*
3. Behavioral indications of pain (facial expressions, restlessness, aggression, moaning, guarding etc.). *The nurse may seek guidance from carers or family members who are familiar with the patient and are able to interpret the patient's behaviors.*
4. Evaluate physiological indicators such as heart rate, blood pressure, respiration rate and temperature. *It must be noted that vital signs are the least sensitive indicators of pain, and should be considered in conjunction with the above mentioned methods of pain measurement.*
5. Analgesic trials involve the administration of low dose opioids and the observation of patient response to opioid titrations. *This assessment should be used as a last resort.*

In addition to the severity of pain, other factors influencing the pain must be assessed to inform the nurse of the true nature of the discomfort. These factors should include:

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- Location: is the pain in relation to a surgical intervention or located in an alternate site? (*ie, is the pain related to something else? Previous and ongoing injury?*)
- Quality: how does the pain feel? (*Burning, aching, stabbing, etc.*)
- Onset and duration: *Constant, intermittent, when did it start?*
- Aggravating and relieving factors: *Does the pain worsen on movement? Positional?*
- Patient expectations: It is important to ensure that the expectations of pain and its management are discussed and explained to the patient. *It is unlikely to relieve pain completely following surgical intervention; rather the goal should be to ease pain to a manageable level that allows for movement, deep breathing and coughing.*
- Other information: Consider other factors including cultural, past medical history and past experiences with pain. *Patients suffering from chronic pain syndromes may require higher doses of opiates, and expectations of pain score may need to be adjusted (ie, medications used for acute pain management may not alleviate chronic pain symptoms).*

(Odom-Forren 2013).

Reassessment of Pain:

Pain assessment is an ongoing evaluation of patient comfort and therefore must be performed at regular intervals depending on the stability of their levels of pain (Schug et al. 2015). For example, while titrating pain protocol in the PACU, pain assessments and reassessments must be frequent and ongoing as long as the opioids are being administered intravenously (*ie, three- five minutely*). When optimal pain control is

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achieved, pain assessments can be reduced to regular intervals ranging from two to four hourly and as deemed necessary thereafter. (Odom-Forren 2013).

Pain Protocol Drugs and Preparation

'The witness to a Schedule 8 medication transaction must be a person who is fully familiar with Schedule 8 medication handling and recording procedures. This would include a registered nurse or registered midwife, an authorised prescriber, a registered pharmacist, and any other person authorised by the registered nurse/midwife in charge of the patient care area to complete this task, such as an enrolled nurse without notation.

Witnessing occurs at the following steps:

- Removal of the medication from the Schedule 8 medication storage Unit and the recording in the Schedule 8 drug register,¹
- Preparation of the medication (as applicable), such as drawing up into a syringe, and labelling, transfer to the patient and first dose administration ¹ and ⁶
- Discarding and rendering as unusable any unused portion of the medication and recorded in the Schedule 8 drug register ¹.
- Where possible witnessing occurs at subsequent aliquot administration as per pain protocol flow chart during the immediate post-operative period in the Post Anaesthetic (SESLHD 2016, section 6.6.3)

In many sites in the SESLHD, there are four opioid preparations used for the administration of intravenous opioid pain protocol. Each drug will be summarized in the table below.

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<u>Drug</u>	<u>Onset</u>	<u>Peak</u>	<u>Duration</u>	<u>Preparation</u>
Morphine: high incidence of N&V; use with caution in those with significant renal impairment, as it is almost completely (90%) excreted by the kidneys, and leaves active metabolites that can prolong effect.	5-10 min	15-30 min	3-4 hours	10mg (1mL) in 9mL of 0.9% Sodium Chloride
Fentanyl: rapid onset and clearance; appropriate for use in those with renal impairment.	3-5 min	10-15 min	2 hours	100mcg (2 mL) in 8ml of 0.9% 0.9% Sodium Chloride
HYDRMorphone: synthetic derivative of morphine; lack of active metabolites makes it appropriate for use in those with renal impairment.	5 min	10-20 min	3-4 hours	2mg (1 mL) in 9ml of 0.9% Sodium Chloride
Oxycodone: synthetic opioid, similar effects to morphine. Use with caution in those with significant renal impairment, as it is excreted by the kidneys.	5-10 min	15-30 min	3-4 hours	10mg (1 mL) in 9ml of 0.9% Sodium Chloride

(Odom-Forren 2013)

Safe Opioid Titration and Monitoring

Pain protocol is an ongoing process of evaluation and observation while administering intravenous opioids. Opioids are given in intermittent bolus doses that are titrated on the basis of the response from each previous dose given. The goal of titration is to provide the smallest dose of analgesia necessary to achieve satisfactory pain relief, while minimising adverse effects (Odom-Forren 2013).

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In accordance with the SESLHD procedure, “Acute Pain Management in the Post Anaesthetic Care Unit: Fentanyl, HYDRomorphone, Morphine and Oxycodone” (2016) and guidelines for acute pain management (ANZCA 2013), it is recommended that intravenous opioid bolus dosing occurs between three and five minutes in order to achieve optimal pain relief. This allows the drug time to reach its peak effect before further doses are administered and minimises the risk of adverse effects including over sedation, respiratory depression and nausea and vomiting (Odom- Forren 2013).

Refer to the table below, for dose administration guidelines as per the SESLHD Procedure: Post anesthetic care unit (PACU) Opioid Pain Protocol for Adults (SESHLD 2016). **Please note:** not all drug preparations are used in all sites in the SESLHD. Please refer to local guidelines for approved preparations at your site.

Refer to “SESLHD Procedure. Acute Pain Management in the Post Anaesthetic Care Unit: Fentanyl, HYDRomorphone, Morphine & Oxycodone” flowchart for frequency of dosing.

Frequent and ongoing patient monitoring and observation is essential to provide safe administration of intravenous opioids. Due to the profound effects of opioids on the central nervous system (CNS), and their narrow **therapeutic ratio**, it is critical to monitor their effects at intervals that reflect the peak effects of the drugs administered. Therefore, in between doses of opioids administered, the PACU nurse **must** monitor and assess the patient’s **sedation score, respiration rate and pain score**. This allows the nurse to evaluate the efficacy of analgesia, while monitoring for adverse effects including respiratory depression and narcotisation (Schug et al. 2015). See below for a reference to sedation score used in reference to pain protocol:

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Sedation Score (Modified Aldrette Consciousness Score)

- 0- Unroutable**
1- Routable to verbal Stimuli
2- Fully Awake

***Please note:** *the Modified Aldrette Consciousness Score differs from the sedation scoring system used in the NSW Pain Management charts. The statewide pain management charts use a 0-3 scale, where 0 is fully awake and 3 is unroutable.**

Patients who are experiencing moderate to severe postoperative pain are all entitled to receive adequate and safe amounts of analgesia. However, there are patients who should not be administered opioid analgesics; such patients include those with:

- 1. Low sedation score (<1), difficulty staying awake, difficult to rouse.**
- 2. Low respiratory rate (<10).**
- 3. Low pain score (≤3).**
- 4. Those with *true* allergies to opioid medications (uncommon).**

In these situations, the addition of non-opioid analgesics is an appropriate and safe method to manage postoperative pain. **Adjunctive pain relief** medications have an opioid sparing effect; that is, they reduce the amount of opioids necessary to achieve satisfactory pain relief. By using a **multimodal approach** to pain management, the clinician can significantly reduce the incidence of adverse effects associated with opioid use, including postoperative nausea and vomiting, severe respiratory depression and narcotisation (Schug et al. 2015). Adjunctive medications commonly used are **Paracetamol, Non-Steroidal Anti Inflammatory Drugs (NSAIDs) i.e. Ibuprofen and Tramadol** (SESHLD 2016).

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Possible Side Effects of Opioid Medications

Respiratory system	Respiratory depression
Central Nervous System	Sedation, nausea and vomiting, miosis, euphoria/dysphoria, muscle rigidity
Cardiovascular System	Vasodilatation, bradycardia, myocardial depression
Genitourinary System	Urinary retention
Gastrointestinal System	Delayed gastric emptying, constipation, spasm of the sphincter of Oddi
Integumentary System	Pruritus (possibly more common with morphine)
Allergy	A “true” allergy is uncommon

(Odom- Forren, 2013).

Possible Complications of IV Opioid Administration

Complications	Management
Sedation	Monitor regularly as per protocol. Sedation score <1 = cease pain protocol, give oxygen. Notify anaesthetist. Naloxone ready to administer.
Respiratory depression	Respiratory rate < 10 = caution. Cease pain protocol. Give high flow oxygen. Assess sedation score, monitor pt closely. Respiratory rate < 5 = Cease pain protocol. Give oxygen. Seek assistance; notify anaesthetist immediately. Monitor patient. Naloxone ready to administer. Stay with patient. Apnoea - patient requires reminding/stimulating to take a breath; naloxone ready to administer.

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Pruritus	Does not always require treatment. If severe notify anaesthetist, change to another opioid. Antihistamines should be avoided due to their sedative effects. Naloxone may be given in low dose but may reverse analgesia.
Nausea and vomiting	Most common side effect. Minimise movement. Administer antiemetic as prescribed (change if ineffective). Notify anaesthetist if unrelieved.

(Odom- Forren, 2013).

Opioid Antagonists

Naloxone (Narcan): is most commonly used for the complete or partial reversal of opioid induced respiratory depression. The goal of naloxone administration is to reverse the respiratory depression while preserving the analgesic properties (POWH 2011).

- Generally titrated to effect beginning with 100-200mcg doses (as prescribed by treating medical officer).
- Onset of action is 1-2 minutes and dosing is recommended to be repeated at 2-5 minutes if adequate reversal has not been achieved (up to 400 mcg).
- The half-life of naloxone is less than that of the opioids it acts upon, therefore, multiple dose administrations may be necessary to fully reverse the effects on the respiratory center.
- If respiratory depression is not adequately reversed by naloxone administration, other causes of sedation and respiratory depression must be considered (i.e. benzodiazepines, inadequate reversal of muscle relaxants—naloxone does not reverse these drugs).
- Rapid reversal from opioid induced sedation and respiratory depression may cause hypertension, tachycardia, nausea and vomiting and severe pain.

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- Naloxone administration in individuals with physical opioid dependence must be performed with caution. Complete reversal of opioids may result in symptoms of acute withdrawal in these types of patients (Odom- Forren 2013).

Naloxone is a pure opioid agonist; therefore can also be used in small doses (40mcg) to reverse other side effects of opioids including nausea and vomiting, and pruritus without reducing the effect of the analgesic properties (Odom-Forren 2013).

Monitoring Post Naloxone Administration

Following the administration of naloxone (for opioid induced respiratory depression), and subsequent stabilisation of the patient, the patient must be monitored on an ongoing basis for one to two hours and until their respiratory rate is consistently above 10 breaths per minute prior to discharge from recovery (POWH 2011). Observations must include: sedation score, respiratory rate and pain score.

Documentation of the events and treatments must be recorded in the patient's notes or SurgiNet (in AdHoc, and events section). In addition, the administration of naloxone must be documented in the NIMC (national inpatient medication chart) or MAR (medication administration record).

Ongoing Pain Management

After achieving adequate pain control using pain protocol (pain score ≤ 3), the patient must remain in PACU for 20 minutes after the last dose of the opioid. If a second syringe has been administered (any or all of the syringe), the patient must remain in the PACU for 30 minutes after the last dose (SESLHD 2016). It is at this time that ongoing analgesic requirements must be considered. Because of the nature of intravenous opioids (rapid onset, short duration), it is essential to provide ongoing pain management using a multimodal method of treatment (ANZCA 2013).

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The concept of multimodal analgesia refers to the use of several types of analgesia that target different pain pathways and with various modes of action (Schug et al. 2015). It is imperative that a considered approach to manage post-operative pain be employed, with consideration given to both short and long acting analgesia, and both opioid and non-opioid treatments; this method has been shown to have an opioid sparing effect on patients undergoing pain management (Schug et al. 2015; ANZCA 2013). Common drugs used in the SESLHD include:

Opioids	NSAIDs	Other
Oxycodone SR (Oxycontin)	Ibuprofen (Nurofen)	Tramadol IR
Oxycodone IR (Endone/Oxynorm)	Paracoxib (Dynastat)	Tramadol SR
Morphine Sulphate (oral or subcutaneous)	Celecoxib (Celebrex)	Paracetamol (Panadol)
MS Contin	Diclofenac (Voltaren)	Paracetamol/Codeine (Panadeine)
Oxycontin/Naloxone (Targin)		Paracetamol/Codeine (Panadeine Forte)
		Gabapentin (Nupentin)
		Pregabalin (Lyrica)
		Amitriptyline (Endep)
		Nortriptyline
		Tapentadol (SR) (Palexia)
		Ketamine

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Section Three

SESLHD Pain Protocol Nursing Assessment (Questionnaire)

1) Define Pain:

2) Name four complications that may occur if severe pain is not relieved in a timely manner.

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- 7) Describe the pharmacological properties of each of the three opioid medications

Drug	Onset	Peak	Duration
Morphine:	5-10 min	15-30 min	3-4 hours
Fentanyl:	3-5 min	10-15 min	2 hours
Hydromorphone:	5 min	10-20 min	3-4 hours
Oxycodone:	5-10 min	15-30 min	3-4 hours

- 8) In which patient population might you see Fentanyl prescribed in favour of Morphine and Why?

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9) What bolus dose (in mL) would you give:

Morphine or Fentanyl:

- a) A patient ≥ 70 yrs with a pain score 1-3:
- b) A patient ≥ 70 yrs with a pain score 4:
- c) A patient ≥ 70 yrs with a pain score 5-7:
- d) A patient ≥ 70 yrs with a pain score 8-10:
- e) A patient < 70 yrs with a pain score 1-3:
- f) A patient < 70 yrs with a pain score 4:
- g) A patient < 70 yrs with a pain score 5-7:
- h) A patient < 70 yrs with a pain score 8-10:

HYDROMORPHONE or Oxycodone

- i) A patient ≥ 70 yrs with a pain score 1-3:
- j) A patient ≥ 70 yrs with a pain score 4:
- k) A patient ≥ 70 yrs with a pain score 5-10:
- l) A patient < 70 yrs with a pain score 1-3:
- m) A patient < 70 yrs with a pain score 4:
- n) A patient < 70 yrs with a pain score 5-10:

10) A 30 year old patient has a pain score of 7/10 a respiratory rate of 26, a heart rate of 120 bpm and a blood pressure of 160/90.

- a) What bolus (mL) of pain protocol would you administer every 3- 5 minutes and when would you stop (until)?

- b) How often would you assess these patients and what would observations would you perform and record?

11) What is the maximum dose recommended on the Pain Protocol?

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12) Name four common side effects of opioids and how you would manage them:

Complications	Management

13) Answer the following questions relating to Naloxone:

a) When would you administer Naloxone?

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14) For how long should you continue to monitor the patient who has had Naloxone?

15) Which of the following Pain Assessment Scale is most commonly used?

16) When is the Abbey Pain Scale used?

17) What criteria must be met prior to discharge from PACU?

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18) Name four common analgesic medications which may be used post operatively after discharge from PACU.

19) What observations are the *most* sensitive indicators of pain?

20) What observations are the *least* sensitive indicators of pain?

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SESLHD - Clinical Competency Assessment 2016

**CORE SKILL – Pain Assessment and Management
(Pain Protocol)**

ACORN Competency Standards	Performance Criteria	Method			* Ratings				
		O	Q	Sim	1	2	3	4	N/A
1. Legislation/ Policy	Utilizes all patient observation data according to protocol Ensures valid medication order Checks drug according to protocol Records drug in register								
4. Assessment	Introduces self to patient, assesses and responds to needs in a timely manner								
	Assesses patient's severity of pain using verbal description, numerical rating scale or Abbey pain scale.								
3. Safe environment	Selects and wears appropriate personal protective equipment (PPE)								
	Provides rationale for patients who are not suitable for pain protocol management.								
	States side effects of chosen opioid								
	Removes equipment from patient area and manages disposal or unused medication according to local policy								
6. Implementation	States principles regarding handling of S8 medications.								
	States the onset time, peak and duration of opioid given								
	Verifies intraoperative analgesia given								
	Confirms drug, dose and expiry date								
	Confirms any patient allergies								
	Performs Hand Hygiene at the 5 points								
	Prepares and Labels Medication for administration accordingly								
	Cleans cannula/port with alcohol swab and allows to air dry Confirms patency of IV cannula prior to medication administration								
	Confirms compatibility of fluid in progress with opioid medication to be administered.								
	Demonstrates occlusion of flow of fluid in tubing above level of access port. Administers correct bolus dose of opioid according to Decision Chart								

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	Ensures cannula is flushed following each administration of medication									
	Ensures patency of IV fluid line is re-established									
	Maintains sterility of syringe in between bolus doses given									
	Discards and documents any unused medication appropriately									
8. Evaluation	Performs ongoing monitoring of patient's physiological and emotional responses before, during and after pain protocol administration									
	Observe IV site and patient for adverse reactions									
	Reports to Anaesthetist if complications arise or if pain is unrelieved									
	Recognises signs and symptoms of an adverse event and describes actions taken									
	Ensure patient pain score is < 3 prior to ceasing pain protocol									
	States recommended timeframe for patients' to remain in PACU post cessation of Pain Protocol									
7. Documentation/ Communication	Documents nursing care according to local policy									

METHOD OF ASSESSMENT

O = Observation of performance **Q** = Questioning to elicit knowledge of criteria

***RATINGS:**

- 1. INDEPENDENT:** Performs independently and consistently, requiring little or no guidance or direction. Is time efficient. Does not require the presence of a preceptor.
- 2. SUPERVISED:** Performs with developing confidence, requiring minimal guidance and direction. Time management is not yet efficient. Requires assistance and information in some areas of practice. Preceptor presence required occasionally.
- 3. DEVELOPING:** Performs with frequent verbal and visual cues from preceptor, requiring moderate guidance and direction. Time is required to perform skills adequately. Constant preceptor presence is required.
- 4. DEPENDENT:** Dependent on preceptor, requiring maximal guidance and direction at all times.

Name: _____

Assessor: _____

Date: _____

**Acute Pain Management of Adults in the Post
Anaesthetic Care Unit:
Intravenous Opioid Pain Protocol Learning Package**

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