

Pain Assessment and Management

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Critical Points

1. This procedure applies to care of patients on Acute Care Units, Transitional Care Units, PACU, Critical Care Units, Emergency Departments, and Ambulatory Care departments.
2. Pain is a prevalent symptom for all patient populations, regardless of age or level of cognitive impairment.
3. Pain control is a high priority and can be managed in most patients.
4. Patients deserve treatment for pain, emphasizing pain prevention, improved function, and realistic goals.
5. Patients deserve to have their pain report accepted by members of the healthcare team.
6. Pain assessments are tailored to meet the needs of each patient based upon age, physiologic condition, medical history, preference, and cognitive/developmental status.
7. Pain assessments should consider a patient's culture and beliefs, underlying meaning of the pain, and associated spiritual and psychological issues or stressors related to pain.

Pain Assessment & Management (*continued*)

Definitions

1. **Comprehensive Pain Assessments** are conducted with any new pain finding/event and/or when a patient is new to the nurse (e.g., upon admission, at shift change, new pain event). Documentation must include location, characteristics, pain level, and acceptable level of pain as reported by patient. The acceptable level of pain is obtained when patients can self-report their pain and considered in the context of function (e.g., what pain level allows patient to ambulate or participate in daily activities). It is appropriate to ask patients about previous doses/durations of therapy used for past pain treatments.
2. **Focused Pain Assessments** are based on knowledge of comprehensive pain assessments and/or knowledge derived from caring for patient (including physical assessment findings). At minimum, document focused pain assessment with vital signs, before and after any pain treatment, and as needed based on patient condition. In settings where frequent vital signs are required (e.g., hourly in critical care areas, etc.), the frequency for conducting a focused pain assessment can be longer than the vital sign frequency. The focused pain assessment includes a pain level/score and sedation level prior to any potentially sedating medication administered for pain. If a new pain event is identified (e.g., previously unidentified pain or new pain in new location), conduct another comprehensive pain assessment.
3. **Multimodal Approach:** Combinations of nonpharmacological methods and medications with different underlying analgesic mechanisms administered to achieve better pain control with lower doses than would be possible with one method or medication alone.
4. **PRN:** Pro re nata (PRN) orders: As needed medication orders used to treat a symptom such as pain. The route and dose are administered by the RN after conducting an assessment of the patient's clinical condition.
5. **Opioid Naïve:** Patients who are not receiving opioid analgesics daily, or patients who have consumed opioids for fewer than 7 days in the 60-90 days prior to hospital admission/clinic visit.
6. **Opioid Tolerant:** Patients receiving at least 60mg oral morphine equivalents (OME) per day for 1 week or longer

Procedure

PAIN ASSESSMENTS

Comprehensive pain assessments: In-depth evaluation when pain is reported or signs of pain observed.

1. Comprehensive pain assessments are obtained with use of an approved pain assessment tool appropriate to the specific patient, population, and condition. Documentation considers each of the following elements:
 - Frequency
 - Location
 - Orientation (right, left, bilateral)
 - Pain level (intensity)
 - Quality (descriptive characteristics such as numbness/tingling, shooting, stabbing, burning, etc.)
 - Pain type (acute, chronic, neuropathic, phantom, referred, cancer, etc.)
 - Aggravating and relieving factors
 - Acceptable level of pain, obtained from the patient whenever possible
2. Assess pain prior to administration of any pharmacological or nonpharmacological interventions and reassess for efficacy and side effects within the required timeframes (see Reassessment section).

Pain Assessment & Management (*continued*)

- Utilization of one pain assessment tool for the duration of the patient's hospitalization is recommended unless the patient's condition warrants a change of tool. Example: The Checklist for Non-verbal Pain Indicators (CNPI) may be appropriate during the perioperative/recovery, then transitioned to a Numeric Pain Scale (NPS) for the duration of the hospitalization.
 - Patients who are unable to report their pain should be assessed with an appropriate behavioral pain scale.
 - Non-verbal pain scores do not measure pain intensity such as on a 0/10 scale. Pain behavior tools simply indicate presence or absence of pain indicators. As a behavior score increases, it is reasonable to assume that pain is increasing. When behavior scores decrease, consider that the pain may be diminishing.
 - Verbal and non-verbal pain scores are not interchangeable. Pain scores may only be compared to others using the same tool.

PAIN ASSESSMENT TOOLS

Pain Assessments help obtain information based on the patient's unique characteristics and needs. See [Appendix A](#) for evidence-based adult pain assessment tools, and [Appendix B](#) for evidence-based pediatric assessment tools.

- **Self-Report scales:** Considered the gold standard pain assessment. Obtain a patient's verbal pain report whenever possible.
- **Behavioral scales:** Observe behavioral signs (e.g., facial expressions, crying, restlessness, and changes in activity) in patients unable to self-report (including cognitively impaired patients or young children).
 - **Caregiver report:** Ask a surrogate who knows the patient well (e.g., parent, family, or caregiver) for information about underlying painful pathology, behaviors indicating pain, and successful home regimens.
 - **Analgesic trial:** Advocate for a PRN analgesic trial if the presence of pain remains uncertain.
- **Assume Pain is Present:** The phrase "assume pain present" (APP) is appropriate for:
 - Unresponsive patients (who cannot self-report and have no pain behaviors to assess), who have underlying pathology thought to be painful (e.g., surgery, mechanical ventilation, etc.).
 - Patients undergoing painful activities/procedures, such as turning, ambulation, physical therapy, removal of tubes, or wound care. The goal is to prevent increased pain.
 - Documenting APP must correspond with a documented activity.

PAIN REASSESSMENT

Pain Reassessments are ongoing and considered part of routine care.

1. This is a focused pain assessment after each intervention to evaluate the effectiveness or side effects of the pain treatment (e.g., sedation, respiratory depression, nausea, constipation or itching).
2. **Documentation** of pain reassessments should minimally include:
 1. **Pain rating** using the same pain assessment tool (eyes closed, resting may be an appropriate entry). The choice to document the patient assessment at rest is available in both the numerical and behavioral pain tools
 2. **Sedation score** (if opioid or other sedating medications were given)
- **Timing of reassessments** are dependent upon the unit and intervention, often corresponding to the peak effect of the treatment.
 - **REQUIRED REASSESSMENT** times are as follows:

Pain Assessment & Management (*continued*)

- ◆ **Within 90 minutes following PO, PR, or enterally administered analgesics**
- ◆ **Within 30 minutes following IV, IM, subcutaneous, and initiation of epidural/peripheral nerve infusion/intrathecal administered analgesics**

RESPIRATION/SEDATION

- Sedation and respiratory depression are common adverse side effects of opioids.
- **Signs of excessive sedation precede signs of respiratory depression (decreased rate and depth of respiration/tidal volume).**
- Decreased oxygen saturation (via pulse oximetry) is a late sign of respiratory depression and should not replace a thorough respiratory assessment.
 - Many classes of medication have sedating properties and may increase the risk of sedation and respiratory depression when given in conjunction with opioids (e.g., benzodiazepines, skeletal muscle relaxants)
- When sedating agents are administered:
 - Assess the patients' level of sedation using an UCSF approved sedation scale (see [Appendix F](#)), based on patient population, patient condition, and goals of care.
 - Respiratory status is part of the pain and/or sedation reassessment. Assess rate, depth, regularity, and noisiness of patient's respirations for one minute to detect altered breathing patterns.
- Address snoring as a sign of respiratory obstruction and reposition the patient to ensure adequate airway is obtained; then reassess.
- Use continuous pulse oximetry (CPO) or capnography as ordered.

SLEEP AND PAIN REASSESSMENTS

Evidence suggests that **patients who experience pain can sleep**, even with severe pain.

1. Wake patient to assess pain and/or sedation if there is any concern. Conduct a full comprehensive respiratory assessment including respiratory rate, depth, regularity and noisiness for a full 60-seconds.
 - It may be acceptable to let the patient rest if they are stable on their pain regimen during the day and have normal respiratory and sedation status; document "Eyes closed, patient calm".
 - Note: Waking a patient will stimulate respirations, so respiratory rate, depth, regularity, and noisiness should be noted before rousing the sleeping patient to obtain a more accurate assessment.

RANGE ORDERS:

- See Range Orders for Pain Management-(General)

PAIN MANAGEMENT PEARLS

Goals of pain management includes patient safety, reduced pain intensity, manageable side effects, improved function, and patient satisfaction.

1. **Conduct visual inspection** each shift during the head-to-toe assessment, looking for "hidden" analgesic therapies (e.g., transdermal patches or implanted infusion devices).

Pain Assessment & Management (continued)

2. **Assess for physiologic indicators:** Consider vital signs, including blood pressure and heart rate, the *least* sensitive pain indicators as they may signal existence of conditions other than pain (e.g., hypovolemia, blood loss). Note: Do not interpret absence of elevated physiologic measures as absence of pain.
3. **Assess for over-sedation:** Review recent medication administration to determine if the patient's sedation could be medication-related. Know the required reversal agents for 2 sedating classes of medications:
 - Benzodiazepines: Reversed by flumazenil (Romazicon)
 - Opioids: Reversed with naloxone (Narcan)
4. **Ask patient/caregivers about:**
 - a. **Dose and duration of home therapies** (see Medication Administration)
 - b. **Effect of pain on daily activity** (e.g., what pain level allows ambulation or participation in physical therapy).
 - Date of pain onset
 - Origination of pain (how and when)
 - Pharmacological and nonpharmacological pain management strategies used prior to admission, their effectiveness and/or adverse effects.
5. **Recognize cultural influences** on the expression of pain. The more differences (e.g., language, race, culture) between staff and patient, the higher the risk of unrecognized and/or undertreated pain.
 - Enlist language translator to assist patients with Limited English Proficiency (LEP) (see [UCSF Medical Center Interpreting and Translation Services](#) policy).
 - Offer LEP patients translated versions of the self-report pain tools.
 - Use a variety of terms when discussing pain, such as "pain," "discomfort," "hurt," "owie" or "ache." Certain terms may be more common across cultures and ages to describe pain intensity.
6. **Routinely incorporate nonpharmacological interventions** as part of the multimodal treatment plan. Document the method used and its efficacy or effect. (See recommended pediatric nonpharmacological treatments in [Appendix B](#)).

PAIN MANAGEMENT EDUCATION FOR PATIENTS / CAREGIVERS

1. Inform patients/caregivers about the importance of a multimodal pain management plan of care including nonpharmacological, non-opioids (e.g., acetaminophen, NSAIDs), adjuvants (e.g., gabapentin), and opioids (if needed) if appropriate and not contraindicated for the patient. Discuss the potentially synergistic effects of this combined approach compared to reliance on one method alone.
2. Discuss common treatments, anticipated effects, and common side effects to monitor.
3. The analgesic orders guide the RN to administer the lowest reasonable dose in the range. The RN conducts a focused reassessment prior to providing additional interventions.
4. Patient's report of pain is valued as the best pain indicator.
5. Ideally, the pain management plan transitions to oral analgesics, and discontinues IV agents when enteral (PO) medications are well tolerated.
6. Tapering medications can be achieved by decreasing dosages and/or extending timeframe between doses.
7. Discuss safe storage and proper disposal of any opioids ordered for discharge.
8. Naloxone (Narcan) will be ordered for reversal of opioid-induced respiratory depression.
9. RNs educate patients/caregivers about the following aspects of pain management:

Pain Assessment & Management (*continued*)

- Terms or methods to describe pain
- The importance of frequent pain assessments and reassessments
- How to report and describe pain based upon the appropriate pain assessment tool.
- Establish acceptable pain levels by identifying functional goals (e.g., coughing, deep breathing, turning, ambulating)
- Reinforce that effective pain management will lead to more successful achievement of goals.
- Provide information about the pain management plan of care, including assessments, treatments, reassessments, pharmacologic and nonpharmacologic interventions to promote comfort and increase function.

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		Dequeker, S., Van Lancker, A., & Van Hecke, A. (2018). Hospitalized patients' vs. nurses' assessments of pain intensity and barriers to pain management. <i>Journal of Advanced Nursing</i> , 74(1), 160-171. https://doi.org/10.1111/jan.13395
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	E3	Ely, E. W., Truman, B., Shintani, A., Thomason, J. W., Wheeler, A. P., Gordon, S., Francis, J., Speroff, T., Gautam, S., Margolin, R., Sessler, C. N., Dittus, R. S., & Bernard, G. R. (2003). Monitoring sedation status over time in ICU patients: reliability and validity of the Richmond Agitation-Sedation Scale (RASS). <i>JAMA</i> , 289(22), 2983–2991. https://doi.org/10.1001/jama.289.22.2983

Pain Assessment & Management (*continued*)

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E2	Lebet, R., Hayakawa, J., Chamblee, T. B., Tala, J. A., Singh, N., Wypij, D., & Curley, M. (2017). Maintaining interrater agreement of core assessment instruments in a multisite randomized controlled clinical trial: The randomized evaluation of sedation titration for respiratory failure (RESTORE) trial. <i>Nursing research</i> , 66(4), 323–329. https://doi.org/10.1097/NNR.0000000000000224
E4	Maatouk, H., Al Tassi, A., Fawaz, M. A., & Itani, M. S. (2019). Nurses' evaluation of critical care pain observation tool (CPOT) implementation for mechanically ventilated intensive care patients. <i>Data in Brief</i> , 25, 103997. https://doi.org/10.1016/j.dib.2019.103997
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A4	University of Iowa. (2021). FACES Pain Scale Revised (FPS-R). Retrieved from: https://geriatricpain.org/faces-pain-scale-revised
FAME Scale details: See nursing policy Policy, Procedure, & Competency Development, Review, & Approval	

Procedure History

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Pain Assessment & Management (*continued*)

Appendix A: UCSF-Endorsed Adult Pain Assessment Tools

Adult Self-Reporting Pain Tools

Tool	Recommended Age and Indications for Use	Recommended Unit/Area for Use
Numeric Rating Scale (NRS) (0-10, eyes closed, patient calm)	<ul style="list-style-type: none"> Ages \geq 6 years to adult; patient must be, able to understand numeric comparisons/quantity 	<ul style="list-style-type: none"> Adult patient care areas
Verbal Descriptor Scale (VDS) (none, mild/moderate/severe, eyes closed/patient calm)	<ul style="list-style-type: none"> Ages >6. Able to understand terms mild, moderate, and severe as comparisons 	<ul style="list-style-type: none"> Adult patient care areas
FACES Pain Scale-Revised (FPS-R)	<ul style="list-style-type: none"> Patients must select the face that best represents their experience of pain in that moment. 	<ul style="list-style-type: none"> Adult patient care areas

Adult Behavioral Pain Assessment Tools*

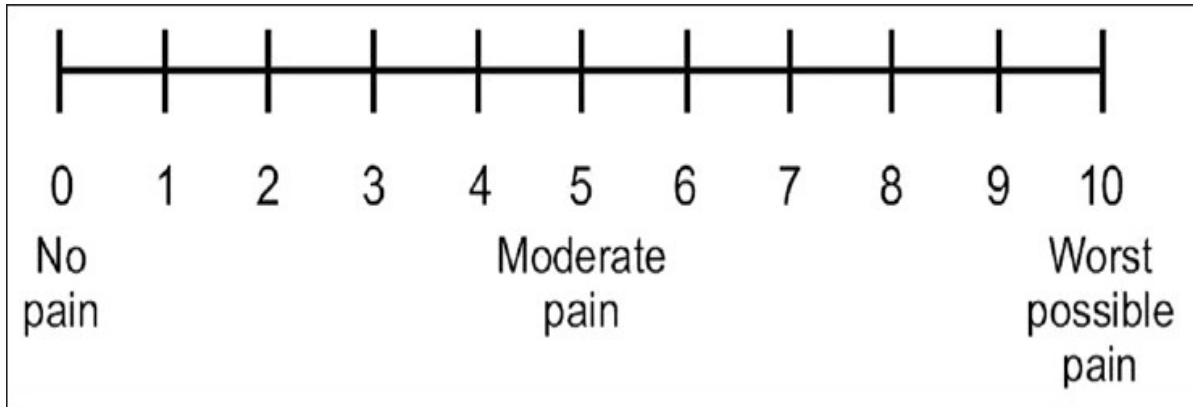
Tool	Recommended Age and Indications for Use	Recommended Unit/Area for Use
Checklist of Nonverbal Pain Indicators (CNPI)	<ul style="list-style-type: none"> Adults unable to self-report 	<ul style="list-style-type: none"> Adult hospital, acute and transitional care units
Critical Care Pain Observation Tool (CPOT)	<ul style="list-style-type: none"> Critically ill adults unable to self-report 	<ul style="list-style-type: none"> Adult critical care areas

1.*Do not interpret behavioral pain scores as pain intensity scores. The behaviors are indicators that pain is present but do not represent intensity.

2.Use behavioral tools only in patients whose behaviors are described in the tool (e.g., movement, verbalizations)

Pain Assessment & Management (*continued*)

Numeric Pain Rating Scale (0-10)



**Consider showing this visual analogue to the patient while asking for a numeric rating

How to Use: Ask the patient, “On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you’ve experienced, at this moment, what number represents your overall pain level?” Patient to select one whole value within this scale.

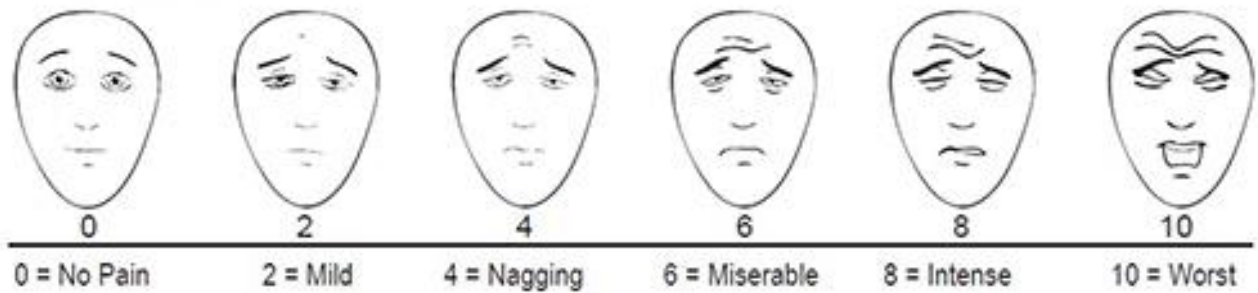
Scoring/Documentation: Numeric has a range from 0 to 10 possible. Document score in medical record (this includes 0 for no pain).

Interpretation: Compare the patient’s acceptable level of pain to the patient’s current self-report of pain to determine level of intervention. This may include nonpharmacologic and pharmacologic interventions. Reassess patient per policy.

Verbal Descriptor Scale: Mild, Moderate, Severe (not always associated with numbers on a numeric rating scale, eyes closed/patient calm)

Pain Assessment & Management (*continued*)

FACES Pain Scale-Revised (FPS-R):



IMPORTANT NOTE: *Patients* must select the face that best represents their experience of pain in that moment.

How to Use: Show patient the faces scale. Explain the tool, “These faces show how much something can hurt.” Point to zero picture and state, “This one shows no pain.” Point to ten picture and state, “This one shows worst pain experienced”. Then ask patient, “What face best represents your pain level right now?”

Scoring/Documentation: Faces Pain Scale-Revised has a range from 0 to 10 possible. Document score in medical record; this includes 0 for no pain.

Interpretation: Compare the patients’ acceptable level of pain to the patients’ current self-report of pain to determine level of intervention. This may include nonpharmacologic and pharmacologic interventions. Reassess patient per frequency per policy.

Pain Assessment & Management (*continued*)

Checklist of Nonverbal Pain Indicators (CNPI)

0 = NOT OBSERVED 1 = OBSERVED WITH MOVEMENT AND/OR AT REST		
BEHAVIOR INDICATORS	WITH MOVEMENT	AT REST
1. Vocal complaints; nonverbal (Sighs, gasps, moans, groans, cries)		
2. Facial Grimaces/Winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)		
3. Bracing (Clutching or holding onto furniture, equipment, or affected area during movement)		
4. Restlessness (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)		
5. Rubbing (Massaging affected area)		
6. Vocal complaints; verbal (Words expressing discomfort or pain [e.g., "ouch," "that hurts"]; cursing during movement; exclamations of protest [e.g., "stop," "that's enough!])		
SUBTOTAL SCORES	+	
TOTAL CNPI SCORE (ADD BOTH SUB TOTALS)	/12	

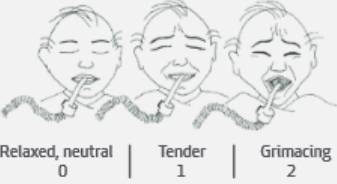
How to Use: Observe the patient for a minute at both rest and during movement before selecting a score for each behavior. Select only one numeric value per observed behavior with movement and at rest.

Scoring/Documentation: Add the scores from the 6 individual behavior areas of at rest and with movement to generate a total CNPI score, ranging from 0 to 12 possible points. Document total CNPI score in the medical record.

Interpretation: Does not provide pain intensity rating. Any score between 1 and 12 can indicate the possibility of the presence of pain in the patient. Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions. Partner with patient's caregivers to determine appropriate interventions. Reassess patient per policy. If upon reassessment the total CNPI score remains consistent or higher, consider a pharmacologic intervention.

Pain Assessment & Management *(continued)*

Critical Care Pain Observation Tool (CPOT)

BEHAVIOR INDICATORS	SCORING DESCRIPTION		SCORE
Facial expressions  <p>Relaxed, neutral 0 Tender 1 Grimacing 2</p>	Relaxed, neutral	0 No muscle tension observed	
	Tense	1 Presence of frowning, brow lowering, orbit tightening and levator contraction, or any other change (e.g., opening eyes or tearing during nociceptive procedures)	
	Grimacing	2 All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)	
Body movements	Absence of movements or normal position	0 Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)	
	Protection	1 Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	
	Restlessness	2 Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	
Compliance with the ventilator (intubated patients)	Tolerating ventilator or movement	0 Alarms not activated, easy ventilation	
	Coughing but tolerating	1 Coughing, alarms may be activated but stop spontaneously	
	Fighting ventilator	2 Asynchrony: blocking ventilation, alarms frequently activated	
OR			
Vocalization (extubated patients)	Talking in normal tone or no sound	0 Talking in normal tone or no sound	
	Sighing, moaning	1 Sighing, moaning	
	Crying out, sobbing	2 Crying out, sobbing	
Muscle tension (Assess last) Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned	Relaxed	0 No resistance to passive movements	
	Tense, rigid	1 Resistance to passive movements	
	Very tense or rigid	2 Strong resistance to passive movements, incapacity to complete them	
TOTAL CPOT SCORE			/8

Pain Assessment & Management (*continued*)

Critical Care Pain Observation Tool (CPOT): Use, Scoring, and Interpretation

How to Use: Observe the patient for a minute before selecting a score for each behavior. Muscle tension should be assessed last as this requires active intervention by the clinician and can alter the other behavior responses. Select only one numeric value per behavior. If the patient is ventilated assess for compliance with the ventilator. If the patient is not ventilated assess for vocalization.

Scoring/Documentation: Add the scores from the 5 individual behavior areas to generate a total CPOT score, ranging from 0 to 8 possible. Document the highest numeric value behavior observed during the minute and the total CPOT score in the medical record.

Interpretation: Does not provide pain intensity rating. Any score between 1-8 indicates the possibility of the presence of pain in the patient. Continue evaluation to identify the potential source of pain and implement appropriate nonpharmacologic and/or pharmacologic interventions. Reassess per policy. If upon reassessment the total CPOT score remains consistent or higher, consider a pharmacologic intervention.

Pain Assessment & Management (*continued*)

Appendix B: UCSF-Endorsed Pediatric Pain Assessment Tools

Pediatric Self-Reporting Pain Tools

Name of tool	Recommended age and indications for use	Recommended unit/area
Numeric Rating Scale (NRS) (0-10, eyes closed, patient calm)	Ages \geq 6 years to adult; patient must be able to understand numeric comparisons/quantity	All pediatric patient care areas
Verbal Descriptor Scale (VDS) (none, mild/moderate/severe, eyes closed/patient calm)	Ages > 6 and able to understand terms mild, moderate, and severe as comparisons.	All pediatric patient care areas
Wong-Baker FACES Scale	Ages \geq 3 years to adult, able to recognize faces	All pediatric patient care areas

Pediatric Behavioral Pain Assessment Tools

Name of tool	Recommended age and indications for use	Recommended unit/area
Neonatal Pain and Assessment Scale (N-PASS)	Premature and term infants 0-100 days of age, and 23 weeks gestation and above	Within pre- and post-op areas, NICU, and PICU
Neonatal Infant Pain Scale (NIPS)	Term newborns – to less than one year	Outside of the Intensive Care Nursery
Face, Legs, Activity, Cry, Consolability (FLACC)	Pediatric patients unable to self-report, ages 2 months to 18 years of age who are unable to self-report pain.	Benioff Children's Hospital, all areas
Pediatric Neuromuscular Blockade (NBA)—AAP/APP	Pediatric patients with neuromuscular blockade	Benioff Children's Hospital, critical care areas

Pain Assessment & Management (*continued*)

NPASS: Neonatal Pain, Agitation & Sedation Scale

BEHAVIOR INDICATORS	SEDATION SCORING	SEDATION		NORMAL/ PAIN	PAIN/AGITATION		PAIN/ AGITATION SCORING
		-2	-1		0/0	1	
Crying Irritability		No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals; Consolable	High-pitched or silent-continuous cry; Inconsolable	
Behavior State		No arousal to any stimuli; No spontaneous movement	Arouses minimally to stimuli; Little spontaneous movement	Appropriate for gestational age	Restless, squirming; Awakens frequently	Arching, kicking; Constantly awake or Arouses minimally no movement (not sedated)	
Facial Expression		Mouth is lax; No expression	Minimal expression with stimuli	Relaxed appropriate	Any pain expression, intermittent	Any pain expression, continual	
Extremities Tone		No grasp reflex; Flaccid tone	Weak grasp reflex; decreased muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay; Body is not tense	Continual clenched toes, fists, or finger splay; Body is tense	
Vital Signs HR, RR, BP, SaO₂		No variability with stimuli; Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline; SaO ₂ 76-85% with stimulation – quick increase	Increase greater than 20% from baseline; SaO ₂ less than or equal too 75% with stimulation – slow increase; Out of sync/ fighting vent	
Gestation/ Corrected age	N/A						
TOTAL SEDATION SCORE	/-10					TOTAL PAIN/ AGITATION SCORE	/13

Pain Assessment & Management (*continued*)

NPASS Use, Scoring, and Interpretation

	SEDATION	PAIN/AGITATION
How to Use	<ul style="list-style-type: none"> • Sedation does not need to be assessed/scored with every pain assessment • Observe the infant for a minute before selecting a score for each behavior. • Select only one numeric value per behavior. 	<ul style="list-style-type: none"> • Observe the infant for a minute before selecting a score for each behavior. • Select only one numeric value per behavior.
Scoring/ Documentation	<ul style="list-style-type: none"> • Sedation scores are negative scores only • Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) • NPASS Sedation total score has a range from 0 to -10 possible. • Document total NPASS Sedation score in the medical record. 	<ul style="list-style-type: none"> • Pain/Agitation scores are positive scores only • Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. • Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. • NPASS Pain/Agitation total score has a range from 0 to 13 possible. • Document the total NPASS Pain/Agitation score in the medical record
Interpretation	<ul style="list-style-type: none"> • Desired levels of sedation vary according to the situation. • Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> • "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> • Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea • "Light sedation": goal score of -5 to -2 • Reassess patient per frequency in local sedation policy <ul style="list-style-type: none"> • A negative score without the administration of opioids/ sedatives may indicate: <ul style="list-style-type: none"> • The premature infant's response to prolonged or persistent pain/stress • Neurologic depression, sepsis, or other pathology 	<ul style="list-style-type: none"> • Does not provide pain intensity rating. • Any score greater than 3 indicates the possibility of the presence of pain in the infant <ul style="list-style-type: none"> • Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). • Reassess patient per frequency of local pain policy. • If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.

Pain Assessment & Management (*continued*)

Neonatal Infant Pain Scale (NIPS)

Neonatal/Infant Pain Scale (NIPS). A behavior-based scale for children who cannot report pain due to age less than one year.

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
FACIAL EXPRESSION	Relaxed Muscles Restful face, neutral expression	Grimace Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression - nose, mouth and brow)	N/A	
CRY	No Cry Quiet, not crying	Whimper Mild moaning, intermittent	Vigorous Cry Loud scream; rising, shrill, continuous	
BREATHING PATTERNS	Relaxed Usual pattern for this infant	Change in Breathing Indrawing, irregular, faster than usual; gagging; breath holding	N/A	
ARMS	Relaxed/Restrained No muscular rigidity; occasional random movements of arms	Flexed/Extended Tense, straight arms; rigid and/or rapid extension, flexion	N/A	
LEGS	Relaxed/Restrained No muscular rigidity; occasional random leg movements	Flexed/Extended Tense, straight legs; rigid and/or rapid extension, flexion	N/A	
STATE OF AROUSAL	Sleeping/Awake Quiet, peaceful sleeping or alert random leg movement	Fussy Alert, restless, and thrashing	N/A	
TOTAL NIPS SCORE				/7

The NIPS assesses six behavioral indicators in response to painful procedures in preterm newborns (gestational age < 37 weeks) and full-term newborns (gestational age > 37 weeks to 6 weeks after delivery).

How to use: Observe the infant for one minute before selecting a score for each behavior. Select only one numeric value per behavior.

Scoring/Documentation: Add the scores from the 6 individual behavior areas to generate a total NIPS score. NIPS has a score range from 0 to 7. Document the total NIPS score in the medical record.

Interpretation: Does not provide pain intensity rating. Any score greater than 2 indicates the possibility of the presence of pain in the patient. Continue evaluation to identify the potential source of pain and implement appropriate nonpharmacologic and/or pharmacologic interventions. Re-assess patient per policy. If upon reassessment the total NIPS score remains >2 consider pharmacologic intervention.

Pain Assessment & Management (*continued*)

FLACC-R (Face, Legs, Activity, Cry, Consolability)

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, sad appears worried	Frequent to constant quivering chin, clenched jaw, distressed looking face, expression of fright/panic	
LEGS	Normal position or relaxed, usual tone & motion to limbs	Uneasy, restless, tense, occasional tremors	Kicking, or legs drawn up, marked increase in spasticity, constant tremors, jerking	
ACTIVITY	Lying quietly, normal positions moves easily, regular, rhythmic respirations	Squirming, shifting back and forth, tense, tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs	Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting	
CRY	No cry. (awake or asleep)	Moans or whimpers; occasional complaint, occasional verbal outbursts, and/or grunting	Crying steadily, screams or sobs, frequent complaints, repeated outbursts, constant grunting	
CONSOLABILITY	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractable	Difficulty to console or comfort, pushing caregiver away, resisting care or comfort measures	
TOTAL R-FLACC SCORE				/10

The Faces-Legs-Agitation-Cry-Consolability – Revised (FLACC-R) is a behavior-based scale for children who cannot report pain either due to age or developmental stage. Suggested for use in children developing normally from ages 1-4 years or in children with developmental delays from ages 1 year to adult.

How to Use: Observe the patient for a minute before selecting a score for each behavior. Select only one numeric value per behavior.

Scoring/Documentation: Add the scores from the 5 individual behavior areas to generate a total FLACC score, ranging from 0 to 10. Document total FLACC-R in the medical record.

Interpretation: Does not provide pain intensity rating. Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient. Continue evaluation to identify the potential source of pain and implement appropriate nonpharmacologic and/or pharmacologic interventions. Partner with patient's caregivers to identify appropriate interventions. Re-assess patient per policy. If upon reassessment the total FLACC score remains consistent or higher consider pharmacologic intervention.

Pain Assessment & Management *(continued)*

Wong-Baker FACES Pain Rating Scale

Wong-Baker FACES® Pain Rating Scale



This tool was originally created for children to help them communicate about their pain.

Pain Assessment & Management (*continued*)

Appendix C: Nonpharmacological Techniques

GENERAL NONPHARMACOLOGICAL CONSIDERATIONS

1. Nonpharmacologic pain management interventions should be age and developmentally appropriate.
2. Ongoing reassessments to assess the effectiveness of these interventions are important.
3. Active Involvement methods:
 - Prepare patients and/or caregivers for anticipated procedures; discuss and rehearse coping techniques.
 - Prepare patient and/or caregiver, providing guidance and direction for pain and anxiety-relieving activities during procedures
 - Assist the family/caregiver in choosing their role during procedures
 - Provide choices to the patient whenever possible to help promote a sense of control and mastery over a painful procedure and hospital experience
 - Make environmental changes: Decrease light and unnecessary noise, provide soothing and/or familiar music, wall and ceiling decorations (pediatrics: murals/posters/decals/mobiles).
 - Cluster nursing and medical care. Provide designated rest periods.
 - Teach the patient and caregiver about the pain management plan, to include assessment, treatments, reassessments, pharmacologic and nonpharmacologic interventions.

AGE-SPECIFIC PEDIATRIC NONPHARMACOLOGIC RECOMMENDATIONS

- Refer to Child Life (pediatric) for initial and ongoing therapeutic play to help develop coping techniques.
- Maintain the patient's room and bed as a procedure-free place. Whenever possible, perform procedures in a treatment room or private room.
- **Neonates:**
 - Containment
 - Swaddling
 - Non-nutritive sucking
- **Infants:**
 - Distraction: Mobiles, toys with music, movement, and/or bright colors
 - Positioning: Swaddle, rocking, nesting, infant swing/carrier
 - Parental presence: Provide parents with a role during procedure
 - Non-nutritive sucking on pacifier
 - Touch: Patting, rubbing, massage, rocking
 - Music: Set tone, relaxation, play/sing soothing or familiar music
- **Toddlers:**
 - Distraction: Music, video, singing, bubbles, pop-up books
 - Positioning: Parent holding, swaddling in blanket, avoid lying down
 - Breathing: Blowing bubbles, pretending to blow candles, wolf puffing down house

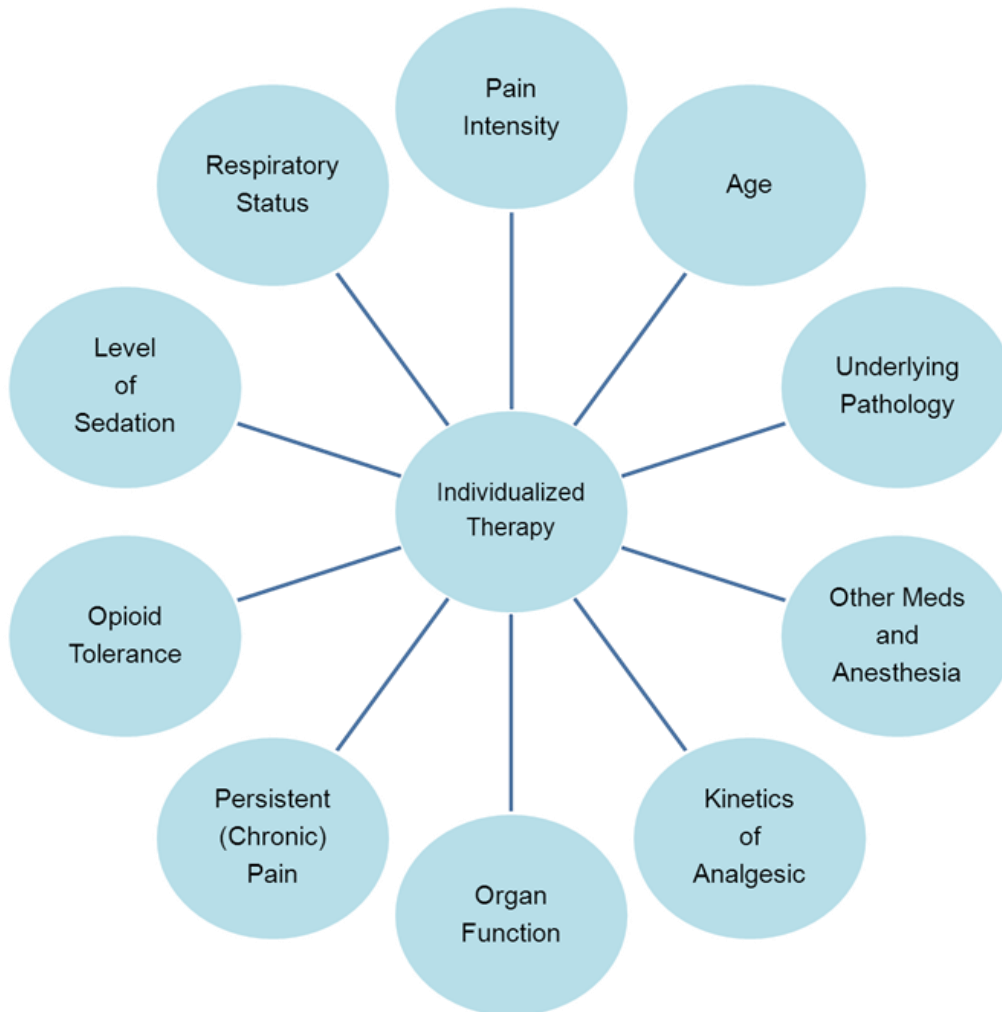
Pain Assessment & Management (*continued*)

- Cutaneous Stimulation: Touch, massage, patting, ice/heat, squeezing on a ball, play dough, or blanket.
Music: Interactive songs or sing along, finger plays
- **School-Age, Adolescents, and Adult:**
 - Distraction: Detailed books, music with headphones, videotapes, video games
 - Parental presence optional based on patient's interests
 - Relaxation Techniques:
 - Progressive relaxation - tensing and releasing the muscles from a distal to proximal progression, i.e., hands, then arms, then shoulders, then face
 - Guided Deep breathing
 - Thought-stopping/positive self-talk
 - Imagery: Using imagination to represent a multi-sensory experience (like a waking dream)

Pain Assessment & Management (*continued*)

Appendix D: Factors to Consider for Individualized Pain Treatment

Consider each of the following when selecting analgesic, route, method of administration, and dose



Pain Assessment & Management (*continued*)

Appendix E: Interventions for Procedures Involving Needles for **PEDIATRIC** Patients

NUMBING THE SKIN

- **4% lidocaine cream (EMLA):**
 - No age restrictions, including infants
 - 30 minutes for effect, shorter with warm packs
 - Can stay on for two hours, works for one hour after removed
- **J-Tips:**
 - When there is no time to wait
 - Children must be older than two years

SUCROSE OR BREASTFEEDING (0-12 MONTHS)

- **Sucrose:**
 - 2 minutes before, lasts 4 minutes
 - May repeat as needed
 - Just a few drops on Pacifier or inside cheek
 - It is the detection of sweet, not amount that triggers the effect
- **Breastfeeding:**
 - Start 2-5 minutes before procedure
 - Continue during procedure

COMFORT POSITIONING

- **Sucrose Swaddling for infants 0-6 months**
- **Upright is the best for children older than 6 months**
- **Parent or caregiver holding or close by**

DISTRACTION

- **Age appropriate**
- **Per-patient preference**

*For adult patients requiring numbing agent for procedure involving needles, please contact the provider

Pain Assessment & Management (*continued*)

Appendix F: Sedation Scales

Pasero Opioid-Induced Sedation Scale (POSS)

POSS Score	Description	Nursing Action
0	Sleep, easy to arouse	Acceptable, no action necessary
1	Awake and alert	Acceptable, no action necessary
2	Slightly drowsy, easily aroused	Acceptable, no action necessary
3	Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable; monitor respiratory status and sedation level closely until stable at less than 3; recommend to decrease opioid dose 25%-50%; consider administering a non-sedating, opioid-sparing nonopioid
4	Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable, stop opioid; consider administering naloxone; notify prescriber or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory

Pain Assessment & Management (*continued*)

Richmond Agitation-Sedation Scale (RASS)

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent nonpurposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive or vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye opening/eye contact) to voice (>10 seconds)	Verbal stimulation
-2	Light sedation	Briefly awakens with eye contact to voice (<10 seconds)	
-3	Moderate sedation	Movement or eye opening to voice (but no eye contact)	
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation	Physical stimulation
-5	Unarousable	No response to voice or physical stimulation	

Procedure for RASS Assessment

1. Observe patient
 - Patient is alert, restless, or agitated. Score 0 to +4
2. If not alert, state patient's name and say to open eyes and look at speaker.
 - Patient awakens with sustained eye opening and eye contact. Score -1
 - Patient awakens with eye opening and eye contact, but not sustained. Score -2
 - Patient has any movement in response to voice but no eye contact. Score -3
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
 - Patient has any movement to physical stimulation. Score -4
 - Patient has no response to any stimulation. Score -5

Pain Assessment & Management (*continued*)

State Behavioral Scale (SBS) (**PEDIATRIC** only)

State Behavioral Scale (SBS) ¹ Score as patient's response to voice then touch then noxious stimuli (Planned ETT suctioning or <5 seconds of nail bed pressure)		
Score	Description	Definition
-3	Unresponsive	No spontaneous respiratory effort No cough or coughs only with suctioning No response to noxious stimuli Unable to pay attention to care provider Does not distress with any procedure (including noxious) Does not move
-2	Responsive to noxious stimuli	Spontaneous yet supported breathing Coughs with suctioning/repositioning Responds to noxious stimuli Unable to pay attention to care provider Will distress with a noxious procedure Does not move/occasional movement of extremities or shifting of position
-1	Responsive to gentle touch or voice	Spontaneous but ineffective non-supported breaths Coughs with suctioning/repositioning Responds to touch/voice Able to pay attention but drifts off after stimulation Distresses with procedures Able to calm with comforting touch or voice when stimulus removed Occasional movement of extremities or shifting of position
0	Awake and Able to calm	Spontaneous and effective breathing Coughs when repositioned/Occasional spontaneous cough Responds to voice/No external stimulus is required to elicit response Spontaneously pays attention to care provider Distresses with procedures Able to calm with comforting touch or voice when stimulus removed Occasional movement of extremities or shifting of position/increased movement (restless, squirming)
+1	Restless and difficult to calm	Spontaneous effective breathing/Having difficulty breathing with ventilator Occasional spontaneous cough Responds to voice/ No external stimulus is required to elicit response Drifts off/ Spontaneously pays attention to care provider Intermittently unsafe Does not consistently calm despite 5 minute attempt/unable to console Increased movement (restless, squirming)
+2	Agitated	May have difficulty breathing with ventilator Coughing spontaneously No external stimulus required to elicit response Spontaneously pays attention to care provider Unsafe (biting ETT, pulling at lines, cannot be left alone) Unable to console Increased movement (restless, squirming or thrashing side-to-side, kicking legs)

Pain Assessment & Management (*continued*)

Appendix G: PRN Analgesic FAST-PACE Assessment Tool



- **F = Functional goals:** Does the analgesia help the patient achieve their mobility goals?
- **A = Airway:** Is there potential risk of respiratory depression? Do they have concurrent sedating medications, sleep apnea, or other airway concerns?
- **S = Sedation score:** How sedated is the patient? Use the Pasero Opioid Sedation Scale (POSS) or Richmond Agitation Sedation Scale (RASS) (in critical care) to determine if it is safe to administer opioids.
- **T = Tolerance to opioids:** Has the patient recently been taking opioids? Does the patient have a history of Opioid Use Disorder (OUD) or Substance Use Disorder (SUD)? If yes, they will likely have increased opioid requirements.
- **P = Pain intensity score:** What is the patient's pain score? It is important to consider the patient's pain report, however, this is just one element of the pain assessment. If the person reports pain that is mild or under control, opioids are generally not needed.
- **A = Age:** Start low and go slow, especially with older adult and children.
- **C = Comorbidities:** Will patients underlying disease state affect how the medication is metabolized or excreted? Check their renal and liver function values.
- **E = Evaluation of pharmacokinetics:** What is the mechanism of action of the drug and how will the drug interact with other agents the patient is ordered?

Pain Assessment & Management *(continued)*

Appendix H: Clinical Opiate Withdrawal Scale (COWS)

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name: _____ Date and Time ____/____/____:_____	
Reason for this assessment: _____	
Resting Pulse Rate: _____ beats/minute <i>Measured after patient is sitting or lying for one minute</i> 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	GI Upset: <i>over last 1/2 hour</i> 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: <i>over past 1/2 hour not accounted for by room temperature or patient activity.</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	Tremor <i>observation of outstretched hands</i> 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	Yawning <i>Observation during assessment</i> 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches <i>If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 skin is smooth 3 piloerection of skin can be felt or hairs standing up on arms 5 prominent piloerection
Runny nose or tearing <i>Not accounted for by cold symptoms or allergies</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	<div style="text-align: right;">Total Score _____</div> <p style="text-align: center;">The total score is the sum of all 11 items</p> Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
 This version may be copied and used clinically.

Pain Assessment & Management (continued)

Appendix H: Withdrawal Assessment Tool Version 1 (WAT-1)

WITHDRAWAL ASSESSMENT TOOL VERSION 1 (WAT – 1)

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Patient Identifier															
		Date:													
		Time:													
Information from patient record, previous 12 hours															
Any loose /watery stools	No = 0 Yes = 1														
Any vomiting/wretching/gagging	No = 0 Yes = 1														
Temperature > 37.8°C	No = 0 Yes = 1														
2 minute pre-stimulus observation															
State	SBS ¹ < 0 or asleep/awake/calm = 0 SBS ¹ ≥ +1 or awake/distressed = 1														
Tremor	None/mild = 0 Moderate/severe = 1														
Any sweating	No = 0 Yes = 1														
Uncoordinated/repetitive movement	None/mild = 0 Moderate/severe = 1														
Yawning or sneezing	None or 1 = 0 ≥2 = 1														
1 minute stimulus observation															
Startle to touch	None/mild = 0 Moderate/severe = 1														
Muscle tone	Normal = 0 Increased = 1														
Post-stimulus recovery															
Time to gain calm state (SBS¹ ≤ 0)	< 2min = 0 2 - 5min = 1 > 5 min = 2														
Total Score (0-12)															

WITHDRAWAL ASSESSMENT TOOL (WAT – 1) INSTRUCTIONS

- Start WAT-1 scoring from the **first day of weaning** in patients who have received opioids +/- benzodiazepines by infusion or regular dosing for prolonged periods (e.g., > 5 days). Continue twice daily scoring until 72 hours after the last dose.
- The Withdrawal Assessment Tool (WAT-1) should be completed along with the SBS¹ at least once per 12 hour shift (e.g., at 08:00 and 20:00 ± 2 hours). The progressive stimulus used in the SBS¹ assessment provides a standard stimulus for observing signs of withdrawal.

Obtain information from patient record (this can be done before or after the stimulus):

- ✓ **Loose/watery stools:** Score 1 if any loose or watery stools were documented in the past 12 hours; score 0 if none were noted.
- ✓ **Vomiting/wretching/gagging:** Score 1 if any vomiting or spontaneous wretching or gagging were documented in the past 12 hours; score 0 if none were noted.
- ✓ **Temperature > 37.8°C:** Score 1 if the modal (most frequently occurring) temperature documented was greater than 37.8 °C in the past 12 hours; score 0 if this was not the case.

2 minute pre-stimulus observation:

- ✓ **State:** Score 1 if awake and distress (SBS¹: ≥ +1) observed during the 2 minutes prior to the stimulus; score 0 if asleep or awake and calm/cooperative (SBS¹ ≤ 0).
- ✓ **Tremor:** Score 1 if moderate to severe tremor observed during the 2 minutes prior to the stimulus; score 0 if no tremor (or only minor, intermittent tremor).
- ✓ **Sweating:** Score 1 if any sweating during the 2 minutes prior to the stimulus; score 0 if no sweating noted.
- ✓ **Uncoordinated/repetitive movements:** Score 1 if moderate to severe uncoordinated or repetitive movements such as head turning, leg or arm flailing or torso arching observed during the 2 minutes prior to the stimulus; score 0 if no (or only mild) uncoordinated or repetitive movements.
- ✓ **Yawning or sneezing > 1:** Score 1 if more than 1 yawn or sneeze observed during the 2 minutes prior to the stimulus; score 0 if 0 to 1 yawn or sneeze.

1 minute stimulus observation:

- ✓ **Startle to touch:** Score 1 if moderate to severe startle occurs when touched during the stimulus; score 0 if none (or mild).
- ✓ **Muscle tone:** Score 1 if tone increased during the stimulus; score 0 if normal.

Post-stimulus recovery:

- ✓ **Time to gain calm state (SBS¹ ≤ 0):** Score 2 if it takes greater than 5 minutes following stimulus; score 1 if achieved within 2 to 5 minutes; score 0 if achieved in less than 2 minutes.

Sum the 11 numbers in the column for the total WAT-1 score (0-12).

¹Curley et al. State behavioral scale: A sedation assessment instrument for infants and young children supported on mechanical ventilation. *Pediatr Crit Care Med* 2006;7(2):107-114.

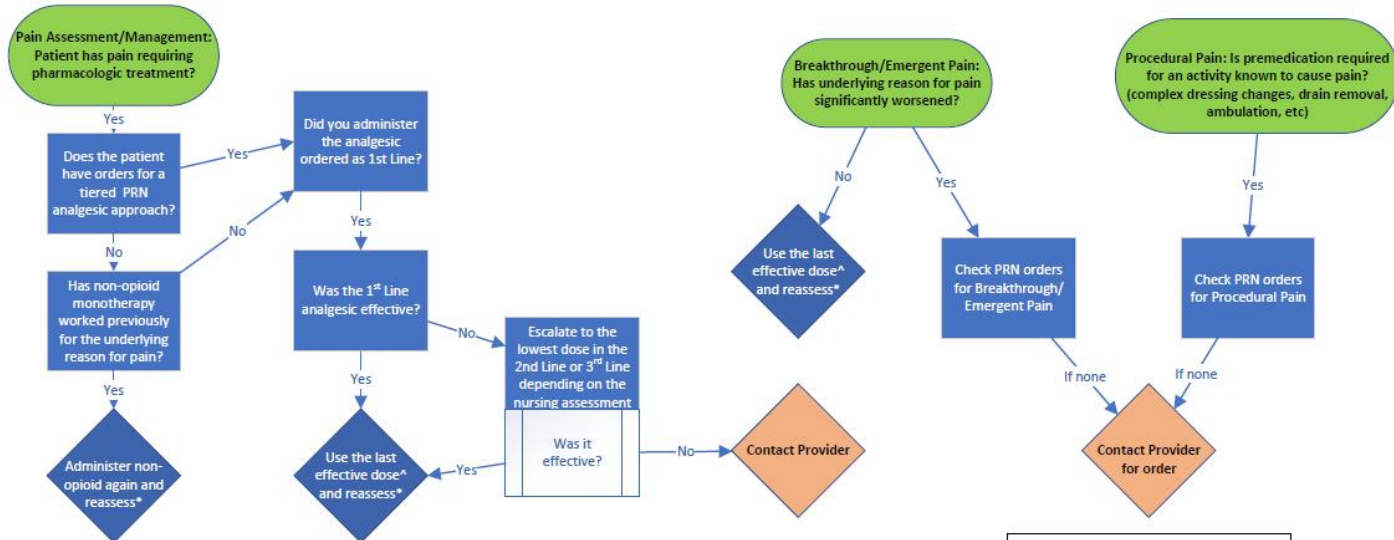
Appendix I: PRN Analgesic Decision Trees for Opioid Naïve

UCSF Health PRN Analgesic Decision Tree For Opioid Naïve* Patients

* Patients who are not receiving opioid analgesics on a daily basis or patients who consume opioids for fewer than 7 days in the 60 days prior to hospital admission
Effective March, 2022

Guiding principles:

- We highly encourage the use and documentation of nonpharmacological methods (for example ice, heat, reposition and distraction)
- Start low go slow. Always reconsider the lowest effective opioid dose in pain management, and slowly increase the dose and/or frequency only if the patient's pain is unresponsive to the previously administered medication
- Administer oral agents prior to IV whenever possible
- Use multimodal therapy and nonpharmacological interventions whenever appropriate
- Contact provider if unclear which medication or dose to administer, if available opioid and non-opioid orders do not control pain, or if intolerable adverse effects are present



* Reassess pain within 30 minutes after an IV dose and 90 minutes after enteral/oral dose
^ Identify the range time interval (e.g. every 4 hours) to determine the total amount of drug already given during that timeframe. The total drug administered within that range must not exceed the maximum dose allowed.



Pain Assessment (continued)

Appendix I: PRN Analgesic Decision Trees for Opioid Tolerant

UCSF Health PRN Analgesic Decision Tree For Opioid Tolerant* Patients

*Patients receiving at least 60 mg oral morphine equivalents (OME) per day for 1 week or longer

Effective March, 2022

Guiding principles:

- We highly encourage the use and documentation of nonpharmacological methods (for example ice, heat, reposition and distraction)
- Start low go slow. Always reconsider the lowest effective opioid dose in pain management, and slowly increase the dose and/or frequency only if the patient's pain is unresponsive to the previously administered medication
- Administer oral agents prior to IV whenever possible
- Educate your patients about multimodal therapy and nonpharmacological interventions
- Contact provider if unclear which medication or dose to administer, if available opioid and non-opioid orders do not control pain, or if intolerable adverse effects are present

*Reassess pain within 30 minutes after an IV dose and 90 minutes after enteral/oral dose

^Identify the range time interval (e.g. every 4 hours) to determine the total amount of drug already given during that timeframe. The total drug administered within that range must not exceed the maximum dose allowed.

FAST-PACE

Assess and Communicate for the Best Administration of Opioids

- F - Functional Goals
- A - Assess
- S - Settle Dose
- T - Transfer to Nurse
- P - Pain Severity Score
- A - Age
- C - Considerable
- E - Evaluate/ET Therapeutics

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Please direct any questions to Marilyn Bazinski, Pain CNS
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