

Fast Facts on Pain Management

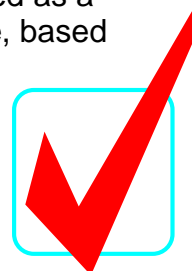
Fast Facts #4 – GENERAL GUIDELINES FOR ANALGESIC MEDICATION ORDERS

It is important to identify basic principles that can guide your practice.

1. **Administer medications routinely, not PRN**
2. **Use the least invasive route of administration first**
3. **Begin with a low dose. Titrate carefully until comfort is achieved**
4. **Reassess and adjust dose frequently to optimize pain relief while monitoring and managing side effects**

Critical Points:

- The character (quality) of the pain has been documented on assessment (e.g. burning/shooting pain) so that the health care provider can determine the type of pain (e.g. neuropathic pain).
 - The oral route is the first choice for analgesic orders. If a patient is unable to take po medications, buccal, sublingual, rectal, and transdermal routes are considered before intravenous or subcutaneous routes.
 - Patients who report constant moderate to severe pain receive a long-acting medication, and have a short acting medication ordered prn for breakthrough pain.
 - Patients who report intermittent pain have medications ordered on a prn basis.
 - Only one combination analgesic (opioid and non opioid, e.g., Vicodin, Tylenol #3) is ordered for prn breakthrough pain.
- Only one opioid is ordered for continuous moderate to severe pain (e.g., MS Contin, Oramorph SR, Kadian, Oxycontin, or Duragesic.)
 - Short acting oral opioids are ordered at intervals no longer than 4 hours.
 - Dose escalation's are calculated as a percentage of the current dose, based upon the patient's pain rating.
 - A rough guideline, assuming normal renal function is pain rated as 3-6/10, dose escalation is 25-50% of current dose; pain rated as 7-10/10, dose escalation is 50-100% of current dose;
 - The frequency of dose escalation is dependent on the opioid preparation in use. Doses of oral/rectal/transdermal opioids can be safely escalated: (assuming normal renal function)
 - Every 1-2 hours-short acting oral/rectal products: morphine, oxycodone, hydromorphone
 - Every 24 hours----long-acting oral opioids MS Contin, Oramorph SR, OxyContin
 - Every 48-72 hours---Duragesic Patch, methadone, levorphanol
 - Prescribe adjuvant analgesics for opioid non-responsive neuropathic pain.
 - Always have an order for breakthrough pain. Use an immediate release opioid at a strength equivalent to 10-20% of the 24 hour dose of the sustained release dose. Order q1-2 hours prn.





- Never have more than one sustained release preparation at one time.
- An appropriate plan for a bowel regimen is ordered to prevent constipation.
- A plan is in place for a pharmacological and / or a non-pharmacological analgesic intervention prior to activities that are reported to cause or increase pain.
- A pain management flow sheet is initiated on all patients rating pain as moderate (e.g. 5/10, 3/5, or 2/3) on admission.
- Orders for non-pharmacological interventions are present and are clearly stated as part of the analgesic plan.
- The metabolites in Demerol and Darvocet are toxic in long-term use and should not be used.

Adapted from the Medical College of Wisconsin, Clinical Resources, Palliative Medicine Program, <http://www.mcu.edu/pallmed>

Sources:

1. Acute Pain Management Guideline Panel. Acute Pain Management: Operative or medical procedures and trauma. Clinical Practice Guideline. AHCPH Pub. No. 92-0032. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services, Feb. 1992.
2. Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain Clinical Practice Guideline No. 9. AHCPH Publication No. 94-0592. Rockville, MD. Agency for Health Care Policy and Research, U.S. Department of Health and Human Services, Public Health Service, March 1994.