Saskatchewan Health Authority

Clinical Procedure

Pain Assessment and Management Corresponds to Clinical Standard: ***CS-CS-0010 Pain Assessment and Management Clinical Standard***	Document Number: **CS-CP-0010** Effective Date: June 22, 2022 Next Review Date: June 2025
Approving Authority: Multidisciplinary Clinical Practice Oversight Committee (MCPOC) **Clinical Procedure Sponsor:** Vice President, Integrated Urban Health & Chief Nursing Officer; Physician Executive, Integrated Urban Health **Clinical Procedure Owner:** Executive Director, Clinical Standards	Revision Dates:
Contact for Interpretation: ***clinicalstandards@saskhealthauthority.ca***	
Beyond Entry Level Type: Not Applicable	
Key words: Injury, surgery, chronic disease, discomfort, multi-modal care, patient centered care	
Refer to **Appendix A** for definitions.	

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CLINICAL TEAM MEMBERS ELIGIBLE TO PERFORM THIS FUNCTION

Approved practice in the care environment, assessment of the patient, and the competence of the individual health care professional are all considerations in the appropriateness of implementing this procedure. Refer to ***CS-CS-0010 Pain Assessment and Management Clinical Standard*****.**

All **Clinical Team Members (CTM)** are eligible to perform these functions within their scope of practice.

EDUCATION AND TRAINING REQUIREMENTS

- CTM are required to be competent in **pain assessment** and management for the diverse populations they serve.
- Competence means CTM have the required knowledge, skills, and judgement to assess and manage **pain**.
- Education materials have been developed to support CTM training and **patient** education (see ***CS-LM-0010 Pain Assessment and Management Learning Module***

EQUIPMENT / RESOURCES NEEDED

Unit/department managers, directors, clinical leaders, clinical coordinators, or educators will:

- Provide the CTM with access to appropriate pain assessment tools for the populations served (see **Appendix E** for recommended tools);
- Provide the CTM information, education, and resources for appropriate pharmacological and non-pharmacological pain prevention and treatment, documentation, and patient education;
- Ensure the CTM has current contact information to escalate care; and
- Oversee development of department/unit pain management protocols, and review regularly with CTM.

GENERAL INFORMATION

Clinical Team Members will adhere to all relevant organizational routine practices prior to the initiation of any procedure including:

1. Clinical Team Members will engage the patients and families in ongoing collaboration in all aspects of care provision: including obtaining appropriate consent prior to the initiation of all procedures, provision of ongoing information sharing, and provision of education as appropriate.
2. Complete a **Point of Care Risk Assessment (PCRA)**. Infection Prevention and Control (IPAC) practices will be adhered to by all team members for all aspects of care. This includes the use of the appropriate Personal Protective Equipment (PPE) and Hand Hygiene as outlined in the **SHA-02-005 Policy: Hand Hygiene.**
3. Verifying the identity of the patient using two (2) identifiers.
4. Identify what specifically should be documented. Refer to **Documentation.**

PROCEDURE

1. PAIN ASSESSMENT AND TREATMENT

The CTM will assess pain, develop or revise the care plan, and treat pain on presentation for care, or on new report of pain by a patient or their support person, or suspicion of change in pain based on **behavioral assessment** (see **Appendix B)**. The CTM will:

- Determine the patient's ability to **self-report** pain based on their developmental, cognitive, and communication status.(1–8) If self-report cannot be used to assess pain, the CTM will select a behavioral assessment tool depending on the patient's capacity to show change in each behavioral category (e.g. a tool that scores changes in breathing cannot be used in a patient who is ventilated). If no behavioral tool is appropriate for that patient, a proxy score will be obtained by a CTM who is familiar with the patient.

- Assess pain as part of the initial history and assessment. The CTM will assess the dimensions required to form a diagnosis and care plan.(9–15) On initial presentation or for assessment of new pain, the CTM will assess more than just pain severity. Other dimensions may include (see **Appendix B)**:
  - Pain onset;
  - Palliating and provoking factors;
  - Location;
  - Timing;
  - Qualitative description;
  - Understanding;
  - Values; and
  - Pain interference with sleep, function, or mood.

- Develop the pain management care plan considering non-pharmacological, pharmacological, environmental, and **self-management** approaches that are clinically and culturally appropriate.(1,3,9,12,13,16–23)
- Use evidence-informed guidelines for safe, responsible, and effective prescribing, tapering, and discontinuation of opioids if used as a component of care.(9,18,21,24–29) The CTM will provide additional support for those who are at a higher risk of substance misuse, such as facilitating timely referral to psychosocial supports or more frequent monitoring.
- Provide pain treatment in a timely manner.(30–32)
- Provide treatment for or facilitate timely access to treatment of conditions that may co-occur with chronic pain and negatively impact treatment outcomes, such as substance use disorders, depression, anxiety, and other mental health disorders.(28,33)

A. Procedural Pain

The CTM will develop a care plan to minimize exposure to pain during potentially painful assessment and treatment procedures.(20, 34–36) The CTM will assess pain and implement the care plan before, during, and after any potentially painful procedures (see **Appendix C**). Longer duration procedures are those in which the procedure has the potential to last longer than the pain prevention measures.

B. Routine Monitoring

The CTM will assess and, if indicated, treat pain routinely at the minimum frequencies to maintain best practice pain management (see **Appendix D**).(8–14,25,27,29,30) Reassessment of pain will be used by the CTM to modify the care plan in collaboration with the patient to ensure the patient's reasonable comfort goals are met or that escalation of care is facilitated in a timely manner.

C. Pain Treatment

The CTM will treat pain and monitor response to treatment by collecting baseline and follow-up assessments with each pain treatment.(8,9,17,25–27,29,37,38)

- The CTM will use the least invasive (such as oral/sublingual or topical) and most clinically appropriate route of medication administration possible for the patient. More invasive routes (such as parenteral or rectal) will be reserved for patients unable to eat/tolerate oral administration, experiencing extensive vomiting or diarrhea, when there are concerns about absorption, OR if clinically indicated (e.g. procedural pain).
- If the patient requires around-the-clock PRN medications to manage pain, the **Most Responsible Practitioner (MRP)** will consider scheduled analgesic administration.
- The CTM will follow a multimodal, opioid-sparing analgesic and non-pharmacological regimen for pain treatment.

- The CTM will assess pain severity and safety risk immediately before administering pain treatments (such as baseline assessment).
- For patients who remain under the direct care of the CTM (e.g. acute care), the CTM will reassess pain severity at a time that coincides with peak effect of the treatment (i.e. follow-up assessment) and monitor for adverse treatment effects throughout the treatment course (see **Appendix F**).
- For patients transitioning to self- or family-care (e.g. home care), the CTM will provide written instructions and check for understanding of pain management and monitoring including:
  - Timing and dose of pain medications or non-pharmacological treatments;
  - How and when to monitor for treatment effectiveness;
  - How and when to monitor for adverse treatment effects; and
  - When to contact a CTM.

D. Treatment Follow-Up

The CTM will monitor for pain relief after treatment (such as a follow-up assessment) at the following frequencies when the patient is under direct care (Refer to **Appendix F** for more details).

i) Parenteral analgesia

- At least once within 15 minutes of administration to check for pain relief. The **Saskatchewan Parenteral Monograph** outlines required monitoring for safety.

ii) Enteral analgesia

- If the patient is receiving a stable, around-the-clock scheduled analgesic medication and the optimal dose has been determined (e.g. no dose changes or new drug administrations for 24 hours), follow-up pain assessments by CTM are not needed. For these patients, pain will be assessed by the CTM once per shift for residents in long-term care, or every four hours for patients in acute care and the emergency department.

i) Transdermal analgesia

- As clinically indicated to achieve optimal pain management.

ii) Local Anesthetic Injection/Patient Controlled Analgesia (i.e. epidural, peripheral nerve blocks)

- The CTM will follow department/unit process or MRP orders for monitoring requirements.

iii) Non-pharmacologic treatments (e.g. warm or cold pack, breath control exercises, comfort positions for infants and children, repositioning, physical activities, transcutaneous electrical nerve stimulation [TENS], manual therapies, acupuncture)

- Following application of treatments expected to have an immediate impact on pain in order to determine if a change in pain treatment is needed. For non-pharmacological pain treatments that are not likely to have an immediate impact (e.g. cognitive behavioral therapy), reassess at the follow-up appointment.

NOTE: Additional monitoring for adverse events or other treatment effects may be required. (9,17,29,37–39).

- Older adults may require up to 90 minutes for **analgesics** to reach peak effect due to pharmacokinetic changes associated with age.

2. PATIENT AND FAMILY EDUCATION

The CTM will provide education about pain assessment and management to the patient and **family**.(9,17,18,25,27,40) The CTM will tailor education to the patient/family's information needs, including language needs, and check for understanding. The CTM will correct common misconceptions about pain as needed using appropriate communication tools during patient education. Common misconceptions include: medications are the only way to treat pain, pain medications are harmful and should not be taken unless pain is excruciating, it's better to not take pain medications so the CTM can make an accurate assessment of what is wrong, infants, people with dementia, or people with cognitive impairment do not feel pain, and chronic pain cannot be treated.

a) The CTM will include information in patient/family education on pain management that is specific to the patient's care plan and pain management needs, including:

- How pain will be treated (the care plan), including accurate information on potential risks and benefits of treatment options;
- The patient's and family's roles in pain management (e.g. how to prepare for diagnostic and treatment procedures) and communication (e.g. when to report inadequate pain relief with treatment or treatment side-effects);
- How to self-manage pain and how family can support pain management:
  - When and how to apply self-management treatments;
  - What signs or symptoms to monitor for safety;
  - When to stop self-management treatments; and
  - When to seek additional care.

b) The CTM will include the following information in patient/family education on pain assessment:

- Why pain is assessed: pain is assessed to determine if a change in treatment is needed.
- Goals of pain treatment: discuss reasonable pain management expectations, such as **comfort goals**. For example, the goal of treatment may not be to eliminate pain, rather to make the patient more comfortable during movement, coughing, breathing, or rehabilitation therapies.
- How pain will be assessed: Provide coaching for the chosen assessment tool(s) and how often pain will be assessed.
  - If possible, orient patients to the pain assessment tool at a time of minimal to no pain.
- How pain assessment will be interpreted: Explain that the patient's pain scores/reports are only compared to their past scores, not to other individuals' scores. Discuss any differences noticed between the patient's pain behaviors and pain self-report score in order to understand the meaning of the score. If necessary, re-orient the patient to the direction of the **pain scale** (e.g. 0 means no pain, 10 means the most pain possible) or use an alternate assessment method (e.g. faces scale instead of numeric rating scale, or a behavioral assessment in those who cannot provide self-report).
- When to report: Encourage patients to report early when pain is not adequately managed, rather than waiting until pain is unbearable.

3. ESCALATION OF CARE

The CTM will inform the MRP if, on routine assessment or reassessment after intervention, pain exceeds the patient's reasonable comfort goals, or severe pain does not respond to ordered interventions.(9,25)

- If necessary, the MRP will contact appropriate medical and non-medical consulting services (e.g. physician specialist, pharmacist, physical or occupational therapists, chiropractor, social work, clinical health psychology, Child Life Specialist, recreation therapist, inter-professional pain or symptom management clinical team) for assessment and care planning.
- The CTM will report undermanaged pain as a patient safety incident if the escalation plan is not effective in reducing pain or if escalation communication cannot be completed (e.g. the MRP cannot be contacted promptly or no consultation service is available).

4. DOCUMENTATION

The CTM will document (9,25,29,40):

- The pain assessment scale/tool to be used to ensure consistency in measurement between different team members;

- Pain assessment findings, diagnoses;
- The pain report provided by the patient without modifying the score provided. Self-report, if it can be obtained, will be prioritized by CTM in documentation; however, more than one assessment approach may be required for a comprehensive assessment if the validity of self-report is questioned (e.g. patient reports no pain but displays overt pain behaviors such as grimace);
- Discussions held with patient about differences between self-report and observational assessment;
- Patient's pain reports in the patient chart according to the department/unit process;
- Pain treatments administered, including clear dosing and frequency instructions for analgesic administration; and
- Painful procedures (e.g. number of blood draw attempts).

REQUIREMENTS FOR CARE TRANSITIONS

1. During all patient care transfers, the CTM will clearly and promptly communicate verbally or in a written report the following information (40):
   - Pain assessment tools/scales or other assessment approaches used;
   - Pain treatments used and team members involved in pain management (e.g. medication doses and timing, non-drug treatment applications, traditional medicines); and
   - Recommendations for follow-up, medication tapers, or other treatment requirements (e.g. procedural pain management care plan, duration of activity restrictions, equipment needs).
2. The CTM will provide the patient with education about pain management and follow-up as a component of the transfer or discharge process. If possible, the CTM will provide the patient with a written care plan that is tailored to the patient's cognitive, language, and literacy capacity requirements.

DOCUMENTS THAT RELATE TO THIS CONTENT

Clinical Standards

CS-CS-0010 Pain Assessment and Management Clinical Standard

Other

CS-LM-0010 Pain Assessment and Management Learning Module

CS-PIER-0021 Understanding Pain Scores

CS-PIER-0022 Four P's of Pain Management and Worksheet

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APPENDIX A - Definitions

Analgesic: A drug used to relieve pain. For the purposes of this clinical standard and clinical procedure, analgesic will refer to any drug given for pain relief, including adjuvant medications (e.g. anti-convulsants and anti-depressants).

Behavioral Assessment Tool (also known as an **observational assessment tool**): A standardized assessment tool that has been developed for pain assessment in a population that is unable to provide self-report of pain. The behavioral assessment tool used must be appropriate for the individual and context.

Clinical Team Members (CTM): In the context of Clinical Standards documents, the clinical team members include those who perform direct patient care. This could include health care professionals, unregulated care providers, practitioner staff, graduates of a recognized professional training program (Restricted license), learners and volunteers.

Comfort goal: The patient/client/resident's (patient's) goal of care related to comfort and function. Specific to pain, the comfort goal is the level of pain that the patient finds acceptable. Ideally, patients will have mild or no pain at rest and only mild to moderate pain during movement that does not significantly interfere with activities. Typically this corresponds to 4 or less on the 0-10 scale, but will vary depending on the patient's treatment goals and usual pain level (e.g. people living with chronic pain may have a higher baseline pain level).Specific to function, comfort goals relate to the patient's ability to comfortably perform meaningful activities such as getting out of bed, sitting for meals, and sleeping.

Family: Individuals who are connected by kinship, affection, dependency or trust. The patient defines their family and how they will be involved in care, care planning and decision making. Individuals identified as "family" may or may not be the substitute heath care decision maker(s). When a patient is unable to define "family" this will be the substitute health care decision maker.

First Nations and Métis Traditional Practitioners: Acknowledged as Knowledge Keepers by the community in the field of First Nations and Métis traditional practices and medicines. They are responsible to the community through the SHA Traditional Knowledge Keepers Advisory Council.(41)

Mixed Pain: Complex overlap of the different known pain types (nociceptive, neuropathic, nociplastic) in any combination, acting simultaneously and/or concurrently to cause pain in the same body area. Either mechanism may be more clinically predominant at any point of time. Mixed pain can be acute or chronic.(42)

Most Responsible Practitioner (MRP): The physician/practitioner with the overall responsibility for directing and coordinating the care of a patient at the specific point in time.

Neuropathic Pain: Pain caused by a lesion or disease of the somatosensory nervous system. Neuropathic pain can originate from the peripheral or central nervous system.(43)

Nociceptive Pain: Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors.(43)

Nociplastic Pain: Pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain.(43)

Pain: An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.(43)

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological, and social factors.
- Pain and nociception are different phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their life experiences, individuals learn the concept of pain.
- A person's report of an experience as pain should be respected.
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological well-being.
- Verbal description is only one of several behaviors to express pain; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

Pain Assessment: The evaluation of the patient's expression of various aspects of the pain experience by questioning the individual, observing behaviors, or obtaining an estimate from a close care-giver. Assessment involves measurement of the pain experiences and impact of pain and evaluation of the context. Responses to questions and observed behaviors vary widely between individuals depending on biological, psychological, and social factors including the cultural background of the individual. For this reason, pain scores (measurements) cannot be compared between individuals. Assessment is performed in order to diagnose, monitor patient status and treatment response, or develop a care plan.

Pain Scale: The tool used to assess pain.

Patient: All individuals including clients, residents and members of the public who receive or have requested health care or services from Saskatchewan Health Authority and its health care providers.

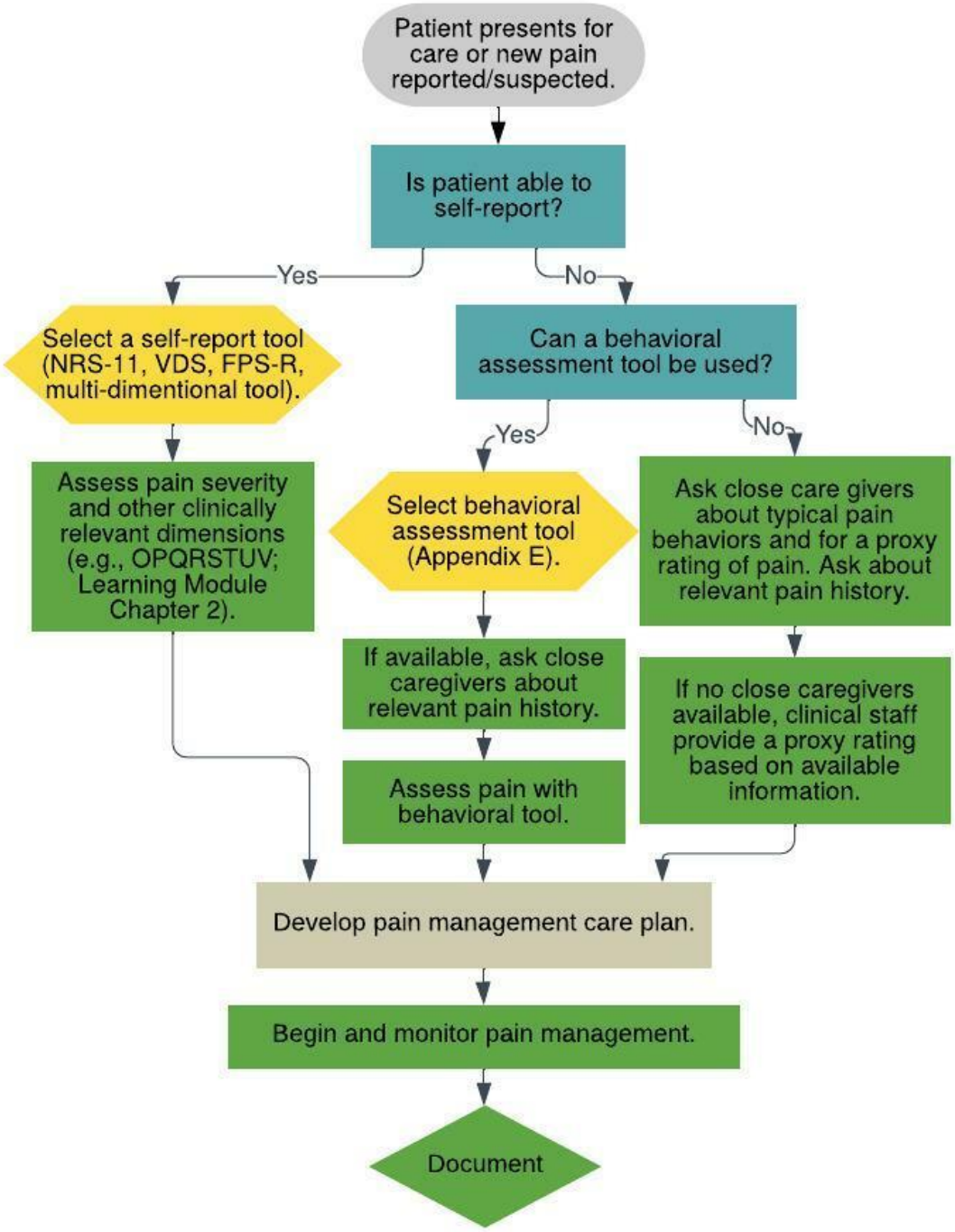
Self-management: Self-management relates to the task that an individual must undertake to live well with one or more chronic conditions. These tasks include problem solving, decision-making, resource utilization, partnerships with health care providers, and taking action.(44)

Self-Report: A response provided to a question about one's own experience.

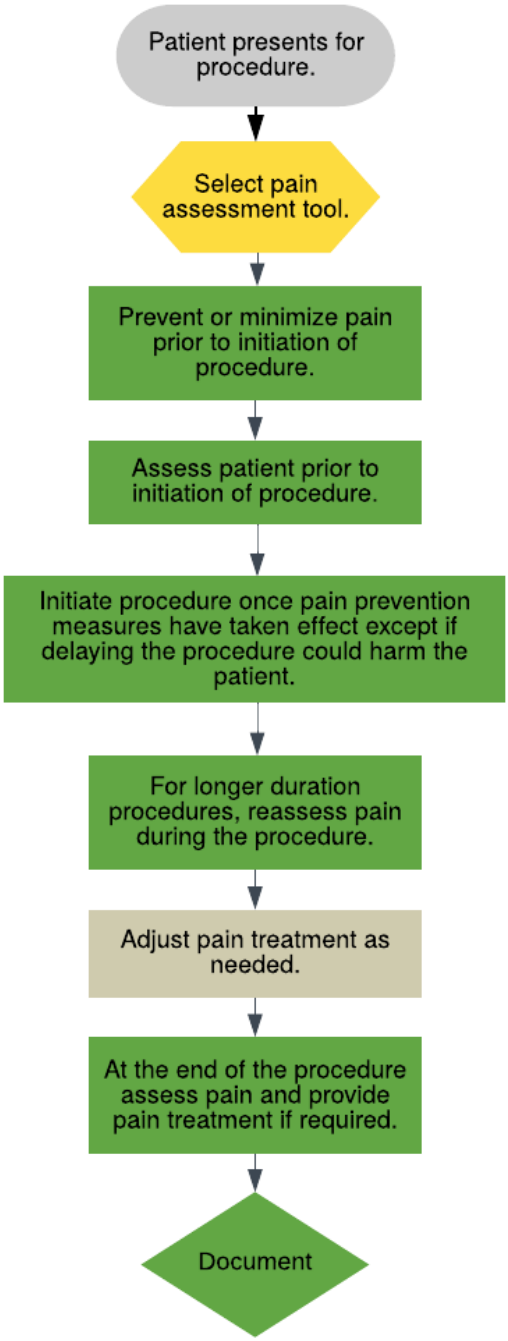
Standardized Assessment: The use of an assessment tool with a consistent approach for that patient/client/resident on each assessment (e.g. all staff using a self-report tool with the same wording, or an observational tool during the same activity).

Verbal Description Scale: A standard set of description words for self-report of pain severity (e.g. no pain, mild, moderate, or severe pain).

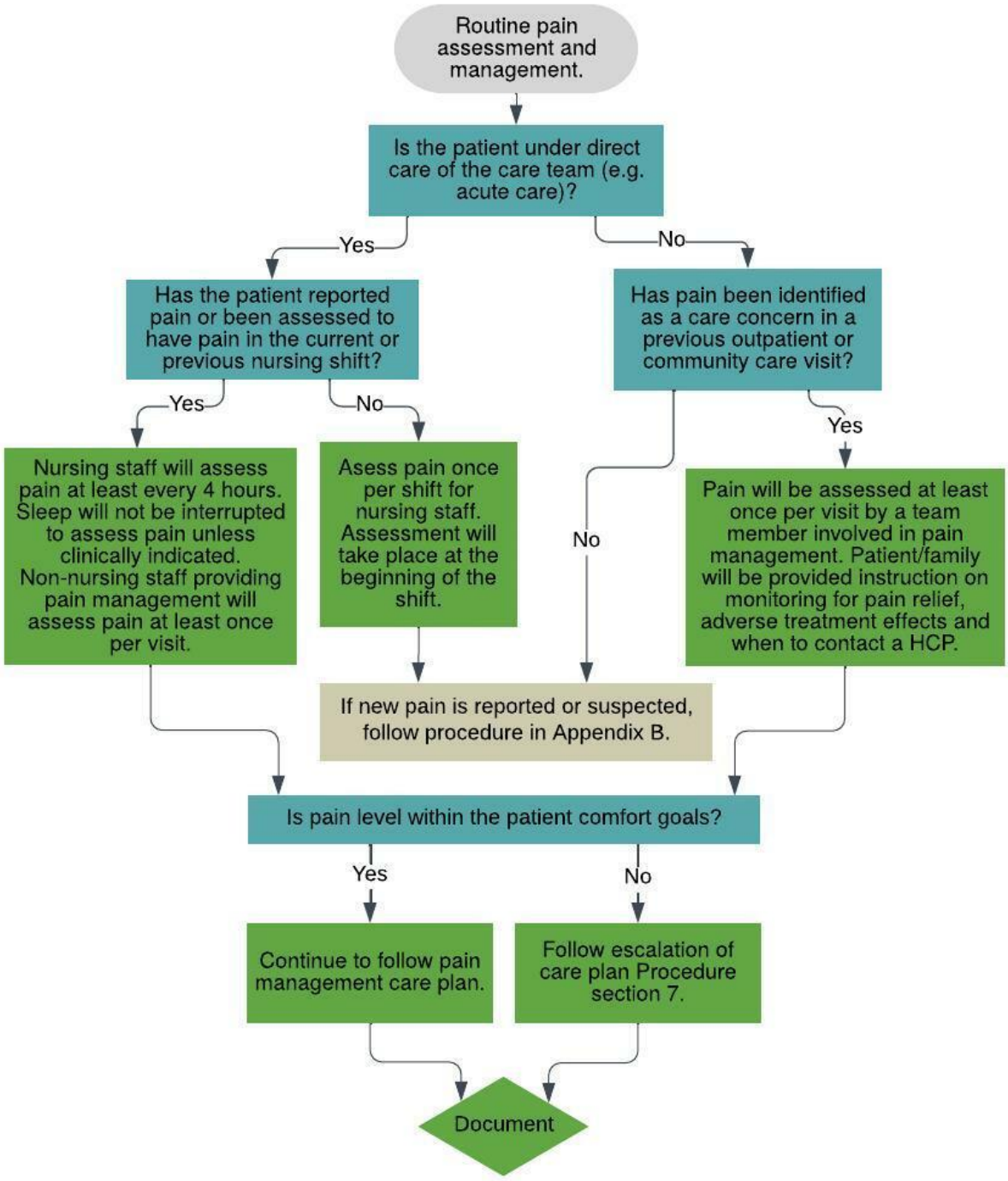
APPENDIX B - Pain Assessment and Pain Management Care Planning on Presentation for Care or New Pain



APPENDIX C - Pain Assessment and Management with Potentially Painful Procedures



APPENDIX D - Routine Pain Assessment and Management



APPENDIX E - Recommended Self-Report and Behavioral Pain Assessment Tools

Pain is a subjective, internal experience; therefore, self-report is the most valid method of measurement and should be used whenever possible.

Three self-report tools are recommended to assess pain severity.(6) See ***CS-LM-0010 Pain Assessment and Management Learning Module* Chapter 2** for more information.

- For adults and children with cognitive development age 8 and older, use the numeric rating scale (NRS-11; 0-10 scale) or verbal descriptor scale.
- For adults or children with cognitive development age 4 and older use the Faces Pain Scale – Revised (**FPSR**).

Many validated tools have been developed for comprehensive assessment of pain of different populations. As a team, consider which assessment tool and domains are most appropriate for your clinical population. The following are examples of comprehensive assessment tools with good validity and reliability.

- Brief Pain Inventory – short form (**BPI**) (45)
- Revised APS Patient Outcome Questionnaire (**RAPSPOQ-R**; in hospital) (46)
- Western Ontario and McMaster Osteoarthritis Index (WOMAC) (47)
- Bath Adolescent Pain Questionnaire (**BAPQ**) (48)

Population	Tool	Additional Information
Pediatric		
Premature and term infants	• N-**PASS** (49) • **PIPP** or PIPP-r (premature to term with monitoring) (50) • **NIPS (0-1 year)** (51) • **FLACC (0-adult)** (52)	Giordano V, Edobor J, Deindl P, Wildner B, Goeral K, Steinbauer P et al. **Pain and sedation scales for neonatal and pediatric patients in a preverbal stage of development: a systematic review.** JAMA Pediatrics. 2019;173(12):1186-1197.
Infants and children 12 months and older	• **CHEOPS** (4 mos – 18 years) (53) • **FLACC** (0-adult) • **FLACC**-r (atypical behaviors) (54)	**Chronic Pain Assessment Toolbox for Children with Disabilities**. Holland Bloorview Kids Rehabilitation Hospital. **Clinical Practice Points**: chronic pain assessment toolbox for children with disabilities. Holland Bloorview Kids Rehabilitation Hospital.
Ventilated/intubated infants and children	• **COMFORT Pain Scale** (0-adult) (55)	Popowicz H et al. **Pain scales in neonates receiving mechanical ventilation in Neonatal Intensive Care Units – Systematic Review.** J Pain Res 2020;13:1883-1897.

Population	Tool	Additional Information
Pediatric		
Post-operative	• **CHEOPS** (4 mos-18 years) • **NCCPC-r** (3-19 years and adolescents with cognitive impairments) (56) • **Pediatric Pain Profile** (PPP) (57) • **FLACC** or **FLACC-r**	Vittinghoff M et al. **Postoperative pain management in children**: Guidance from the pain committee of the European Society for Paediatric Anaesthesiology. Pediatric Anesthesia 2018;1-14.
Cognitive impairment	• **FLACC-r** • **NCCPC-r** **(**3-18 years) • **PPP**	
Adult		
Cognitive impairment	• **Checklist of non-verbal pain indicators** (CNPI) (58)	
Dementia-related cognitive impairment	• **PAINAD** (58) • **PACSLAC-II Single Assessment** (SHA 0224) (59) • **PACSLAC-II Multiple Assessment** (SHA 0225) • **DOLOPLUS 2** (60)	For more information see **geriatricpain.org** The Behavioral Supports Ontario-Dementia Observation System (**BSO-DOS**) tool is commonly completed for a series of days in conjunction with behavioral pain assessment tools such as the PAINAD or PACSLAC to track behaviors that may be related to pain and or dementia.
Critical care	• **Critical Care Pain Observation Tool** **(CPOT**) (61)	

APPENDIX F - Onset, Peak and Duration of Common Pain Medications (62–66)

NOTE: This table is intended as a quick reference tool to guide timing of reassessment after treatment. Pain relief should be reassessed at a time coinciding with time of peak treatment effect. Additional monitoring may be required to monitor adverse treatment effects throughout the course of treatment (such as duration of action). Please refer to medication monographs, **LexiComp**, **RxFiles Pain Book** , The Hospital for Sick Children Electronic Formulary (within LexiComp), and BC Children & Women's Online Formulary (**C&W Formulary**) for additional information about prescribing and dosing recommendations.

Acetaminophen and Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)					
Medication	**Onset of Action (minutes)**	**Peak Effect (hours)**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Acetaminophen	30-60	0.5	4-6	Oral Rectal	AE: Headache, nausea, vomiting May cause hepatic complications in doses over 3000 mg/24 hours in the elderly. Use cautiously in patients with known cirrhosis or severe hepatic dysfunction. **Pediatric patients** may vary in response time depending on GI motility.
Ibuprofen	15-60	0.5	6-8	Oral	AE: Nausea, vomiting, headache, dizziness, rash, heartburn, hyperkalemia, cardiovascular risks, gastrointestinal bleeding. Not recommended for use with moderate to severe renal impairment. Caution in patients with congestive heart failure or concurrent nephrotoxic medications. **Pediatric patients** Suspension formulations can have peak effect within 30 minutes. Typically not used (outside of PDA closure) in infants less than 1 month of age; caution with use less than 6 months of age.

Acetaminophen and NSAIDs					
Medication	**Onset of Action (minutes)**	**Peak Effect (hours)**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Naproxen	30-60	1-2	Up to 12	Oral Rectal	AE: Headache, dizziness, rash, edema, alterations in blood pressure, abdominal pain, cardiovascular risks, gastrointestinal bleeding. Not recommended for use with moderate to severe renal impairment.
Ketorolac	30-60	Oral/IV/IM: 2-3	4-6	Oral IV/IM	AE: Headache, stomach upset, gastrointestinal bleeding, nausea, dizziness, drowsiness, cardiovascular risks. Not recommended for use with moderate to severe renal impairment. Not to be used for greater than 5 days of therapy.
Celecoxib	60	3	12-24	Oral	AE: Diarrhea, dyspepsia, abdominal pain, increased liver enzymes, upper respiratory tract infection, hypertension, nausea, and headache. Not recommended for use with severe renal impairment. Monitor closely in chronic hepatic dysfunction. **Pediatric patients** can have peak effect as early as 1 hour.
Indomethacin	30	2	4-6	Oral Rectal	AE: Headache, vomiting, dizziness, drowsiness, dyspepsia, gastrointestinal bleeding, pruritus, confusion in elderly, cardiovascular risks. Not recommended for use with moderate to severe renal impairment.

Acetaminophen and NSAIDs					
Medication	**Onset of Action (minutes)**	**Peak Effect (hours)**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Diclofenac	30-60	1 May vary based on formulation	Approximately 8-12	Oral (Also available as topical agent -section below)	AE: Abdominal pain, diarrhea, indigestion, edema, gastrointestinal bleeding, constipation, cardiovascular events (MI), hypertension, cardiovascular risks. Peak effect may be delayed when taken with food.
Opioid Analgesics**					
Codeine	15-30	0.5-1	4-6	Oral: IR and CR	AE: Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritus. **NOTE:** Requires conversion to active metabolite by CYP2D6 enzyme; some patients may not respond and some may respond strongly. **Pediatric patients**: STRONG contraindication due to variability in CYP2D6 enzymes which may result in overdose and death.
Oxycodone	IR: 15	IR: 1-2 CR: 4-5	IR: 3-4 CR: 8-12	Oral: IR and CR	AE: Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritus. Immediate release and controlled-release formulations available. May cause more euphoria compared to other opioids.

Opioid Analgesics**					
Medication	**Onset of Action (minutes)**	**Peak Effect (hours)**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Morphine	Oral: 15-6 IV: 5-10	Oral: 1 IV: 20 min	Oral/IV/IM Subcut.: 3-6	Oral: IR and SR IV/IM/Subcut. Rectal	AE: Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritus. There are many sustained-release products available. Time to peak effect is highly dependent on the formulation. Caution in renal dysfunction.
Hydromorphone	IR: 30 CR: 6 hours	IR: 0.5-1 CR: 9	IR: 3-4 CR: 13	Oral: IR and CR IV/IM/Subcut.	AE: Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritus. Immediate release and controlled-release formulations available.
Methadone	2 hours	1-2 Full analgesic response: 3-5 days	4-8	Oral	AE: Sedation, nausea/vomiting, constipation, delirium, pruritus, life-threatening QT prolongation. Monitor closely for respiratory depression, especially within the first 24-72 hours (titrate doses carefully). Available in tablets and liquid formulation.

Opioid Analgesics**					
Medication	**Onset of Action (minutes)**	**Peak Effect (hours)**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Fentanyl (systemic)	IV: almost immediate IM: 7-8 Buccal:10-15	IV: several minutes	IV: 0.5-1 IM: 1-2	IV/IM/Subcut. Buccal Sublingual Intranasal	AE: Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritus. For breakthrough or incident pain.
Fentanyl (patch)	Variable, some sources reporting 6 hours.	20-72; May take up to 6 days (2 patch cycles) for fentanyl levels to reach equilibrium on a new dose	72	Transdermal Patch	AE: Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritus  **ALERT:** Do not initiate in opiate naïve patients. Monitor patients closely for respiratory depression, especially within the first 24-72 hours of initiating therapy. Rotate transdermal patch to different skin sites after removal of the previous patch. Do not apply to those with elevated body temperature such as heating pads, hot baths, or fever.
Tramadol (non-formulary in SHA)	60	2-3	6	Oral	AE: Drowsiness, constipation, vertigo, nausea, headache, somnolence, agitation, anxiety, emotional lability. Undergoes conversion by CYP2D6 enzyme; some patients may not respond and some may respond strongly.

Antidepressants (Common medications for neuropathic or nociplastic chronic pain)					
Medication	**Onset of Action**	**Peak Effect**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Amitriptyline	Pain Control: 2-5 hours Depression/ Chronic Pain: 1-2 weeks	Pain: 2-5 hours Depression/ Chronic Pain: 2-4 weeks at max tolerated dose for	N/A	Oral	AE: Sedation, dry mouth, nausea, confusion, urinary retention, weight gain, blurred vision, QT prolongation. Use with caution in patients with cardiovascular disease.
Nortriptyline	Pain: 4-8 hours Depression/ Chronic Pain: 1-2 weeks	Pain: 3-5 days Depression/ Chronic Pain: 2-4 weeks at max tolerated dose	N/A	Oral	AE: Sedation, dry mouth, nausea, confusion, urinary retention, weight gain, blurred vision, QT prolongation Use with caution in patients with cardiovascular disease. May be preferred in elderly due to potentially better tolerability.
Duloxetine	Pain: 5-6 hours Depression/ Chronic Pain: 1-2 weeks	4-6 weeks at therapeutic dose	N/A	Oral	AE: Nausea, dry mouth, dizziness, headache, insomnia, fatigue. Administer with food to decrease GI adverse effects. Consider morning administration to prevent insomnia. Contraindicated in severe renal or hepatic dysfunction.

Gabapentinoids (Common medications for neuropathic or nociplastic chronic pain)					
Medication	**Onset of Action**	**Peak Effect**	**Duration of Action (hours)**	**Route of Administration**	**Adverse effects (AE)/Comments**
Gabapentin	1-2 weeks	4 weeks at therapeutic dose	N/A	Oral	AE: Dizziness, drowsiness, confusion, peripheral edema. Potential for abuse. Increased risk for respiratory depression when combined with opioids. Adjust dose for renal dysfunction.
Pregabalin	1-2 weeks	4 weeks at therapeutic dose	N/A	Oral	AE: Sedation, dizziness, peripheral edema. Use with caution in patients with moderate to severe heart failure. Potential for abuse. Increased risk for respiratory depression when combined with opioids. Adjust dose for renal dysfunction.
Topical Agents					
Diclofenac	1-2 days Varies	1 week	6-8	Topical	AE: skin irritation, pruritus, rash, increased sun sensitivity (rare). Do not apply to skin with cuts or rashes.

Topical Agents					
Medication	**Onset of Action**	**Peak Effect**	**Duration of Action**	**Route of Administration**	**Adverse effects (AE)/Comments**
Lidocaine	3-5 min.	Varies by product	Varies by product	Topical	AE: application site reactions, skin irritation, pruritus, rash.
Capsaicin	1-2 weeks	2-4 weeks	6-8 hours	Topical	AE: erythema, pruritis, application site pain, skin papules. Do not apply to skin with skin that is damaged, broken, or irritated or in skin folds. Do not use with external heat sources (e.g. heating pad). Do not apply within 1 hour of bath, shower, hot tub, or sauna. Do not cover with bandage.
Other Analgesics (Commonly used in management of pediatric procedural pain)					
24% Oral Sucrose	Administer a small dose prior to the procedure and repeat throughout.	50 seconds	1-2 minutes	Oral	AE: None Most effective as a mild analgesic agent for infants from birth to 18 months Calming effects are independent of the volume administered. Ineffective if given directly into the stomach via a nasogastric tube.

IR = immediate release; SR = sustained release; CR = controlled release; IM = intramuscular; IV = intravenous; Subcut = subcutaneous
*Not a complete list of analgesic medications/categories (most common medications used in SHA)
**Patients who are on chronic opioid therapy or are suffering from opioid use disorder will require higher doses of opioids for analgesia than opioid-naïve patients.

APPENDIX G- Replaced Documents

SHA Clinical Standards and procedures replaces all related:

- departmental,
- unit, or
- former regional documents.

Teams may need to update local work standards to make sure they are not different from SHA Clinical Standards and procedure before they continue to use them.

This clinical standard and procedure replaces or partially replaces the following former regional health authority policies, procedures, forms or other related documents including but not limited to:

Policy/Procedure- Full Repeals

Cypress	Pain Assessment and Management Policy	4-E-390
Five Hills	Pain Assessment Policy	IX-500
Heartland	Pain Assessment and Management Policy and Procedure	C01-38
Heartland	Pain Assessment and Management Approved Pain Severity Scales – Exhibit	C01-38.02
Heartland	Pain Assessment PAINAD Poster - Exhibit	C01-38.04
La Ronge	Palliative Pain Assessment Cheat Sheet	No number
Prince Albert Parkland	Adult Pain Assessment Policy	170-10-78
Prince Albert Parkland	Pain Assessment and LTC Tool	170-60-23
Prince Albert Parkland	Pain Assessment Tool Guide	No number
Prince Albert Parkland	Adult Pain Assessment Tool	No number
Prairie North	Pain Management Policy and Procedure	10500
Prairie North	Pain Management in Labour Policy	11435
Prairie North	Pain Management in Labour Procedure	11435(P)
Prairie North	Pain Management – Pediatric Newborn Care - Policy	11504
Prairie North	Pain Management – Pediatric and Newborn Care Procedure – Appendix A	11504(A)

Prairie North	Pain Management - Pediatric and Newborn Care Procedure – Appendix B	11504(A)
Prairie North	Pain Management - Pediatric Newborn Care Procedure – Appendix C	11504(A)
Prairie North	Pain Management - Pediatric and Newborn Care Procedure	11504 (P)
Prairie North	Numeric Pain Scale	10500(A)
Prairie North	Pain Management Guidelines Cognitively Well	10500(A) Appendix A
Prairie North	Developmental Differences of Children According to Age	11504(A)
Prairie North	Pain Rating Brochure	No number
Regina Q'Appelle	LTC Pain Management Algorithm	1072
Regina Q'Appelle	PAINAD Graph	080
Saskatoon	Pain Management – Pediatric Care Policy	1045
Sun Country	Pain Management Protocol	IPC_00_12_00
Sun Country	Chronic/Palliative Care Medication Guideline	IPC_00_12_00 Exh. A, Exh. B
Sunrise	Pain Assessment Policy	810.022
Sunrise	Regional Pain Management Committee Terms of Reference	110.072
Sunrise	PACSLAC	12_B2-3
Sunrise	PACSLAC Instructions	12_B1
Sunrise	PACSLAC II	12_B
Sunrise	PAINAD Instructions	12_B4
Sunrise	PAINAD Item Definitions	12_B6
Sunrise	PAINAD Item Definitions 2	12_B7
Sunrise	Pain Graph for PACSLAC	12

Sunrise	PAINAD Tool	12
Sunrise	Faces Pain Scale Revised	12
Sunrise	Neonatal and Pediatric Procedural Pain Management – Nursing Policy	601.004
Sunrise	Pain Assessment	760.006
Sunrise	Neonatal and Pediatric Procedural Pain Management – Policy	831.005
Sunrise	Neonatal and Pediatric Procedural Pain Management - Procedure	831.005.1

Policy/Procedure- Partial Repeals

Five Hills	Pain Assessment Tool	No number
Kelsey Trail	Pain Management Policy and Procedure	G-16-10
Prince Albert Parkland	Pain Physiology & Assessment – Patient Controlled Analgesia Epidural & Spinal Analgesia Nerve Block Catheters Self Learning Package	No Number
Prince Albert Parkland	Pain Management in PACU Learning Package	No Number