QUALITY ASSURANCE PACKET

- Commitment to Cancer Pain Management Statement
- Patient Rating Guide
- Patient Outcome Questionnaire
- Chart Audit Tool
- Pain Assessment Flowsheet
- Palliative Care Protocol
- MS Drip Protocol
- Care of Patient Experiencing Cancer Related Pain

Developed by:
Saint Luke's-Shawnee Mission Health System
Shawnee Mission Medical Center
9100 W. 74th Street
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Saint Luke's Shawnee Mission Health System

Commitment to Cancer Pain Management

Because effective pain relief can greatly improve the quality of life of our patients, Saint Luke's Shawnee Mission Medical Center Health System is committed to providing high quality, safe pain management for all cancer patients across geographic care settings. With national guidelines and recommendations at its foundation, cancer pain management is a process, rather than a circumstance, characterized by continual evaluation of practice and progress toward improvement of outcomes, including:

- *increased comfort*
- *reduced side effects*
- *fewer complications*
- *enhanced patient satisfaction and*
- *increased cost effectiveness*

Through interdisciplinary collaboration and problem-solving, the process of pain management is integrated into care delivery models, documentation systems, policies, procedures, and protocols, orientation and educational programs. Ongoing education and the availability of clinical experts are resources to help physicians, staff members, patients and families successfully manage pain as evidenced by achievement of the patient's goal for pain relief.

Adopted by the Saint Luke's Shawnee Mission Health System
Cancer Pain Management Quality Improvement Team, January, 1998

Why do we ask you about the level of your pain?

Relief of pain can greatly improve healing and quality of life. Your doctors and nurses are committed to providing you with the best pain control.

- Pain feels different to different people.
- We want you to be able to tell us what YOUR pain feels like.
- Assigning your pain a number will help us relieve your pain.
- Your health care team will use this number to make your pain better.
- We care about your pain and well-being.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Little		Medium		Quite A Lot		Very Bad		Worst Pain Ever

PAIN RATING GUIDE

Other ways to look at your pain.

Does your pain get in the way of . . .		
❑ Hobbies ❑ Relationships with others ❑ Walking ability ❑ Ability to concentrate	❑ Sleep ❑ Appetite ❑ Mood	❑ Ability to do personal care (i.e. bathing) ❑ Normal Work Routine (job, housework) ❑ Enjoyment of life's pleasures

[Faces pain scale could not be reproduced with current software. You may order this information from the City of Hope Pain Resource Center Index.]

PATIENT OUTCOME QUESTIONNAIRE
(to be filled out by interviewer)
St. Luke's Shawnee Mission Health System

Inclusion criteria: Non-surgical cancer patients with diagnosis of:
Primary site of cancer being pancreas, bone, lung / trachea / bronchus
Metastatic cancer
Bone Marrow Transplants

MR #:	**Date of Survey:**	**Total time required to complete questionnaire** **min**	**Signature of Surveyor:**
Case #:	**Day of Service (with admit day being day 1)**		
Diagnosis:	**Physician doing primary pain management:** **Name:** **Number:**		

1. At any time during your care have you needed treatment for pain? □ yes □ no
2. Have you experienced any pain in the past 24 hours? □ yes □ no

On a scale of 0 to 10, with 0 being no pain and 10 being worst pain, please answer the next three questions.

3. On this scale, how much discomfort or pain are you having right now? Rating: _____
4. On this scale, please indicate the worst pain you have had in the past 24 hours. Rating: _____
5. On this scale, please indicate what is an acceptable level of pain for you. Rating: _____

6. Select the phrase that indicates how satisfied you are with your pain management:
very satisfied, satisfied, slightly satisfied, slightly dissatisfied, dissatisfied, very dissatisfied

7. When you asked for pain medication, what was the longest time you had to wait to get it?

15 minutes or less, 15-30 minutes, 30-60 minutes, more than 1 hour, never asked for pain medication

8. Was there a time that the medication you were given for pain didn't help and you asked for something more or different to relieve the pain? □ yes □ no
If your answer is "yes", how long did it take before your doctor or nurse changed your treatment to a stronger or different medication and gave it to you?
less than 1 hour, 1-2 hours, 2-4 hours, 4-8 hours, 8-24 hours, more than 24 hours

9. Early in your care, did your doctors or nurses discuss with you that we consider treatment of pain very important, and did they ask you to be sure to tell them when you have pain? □ yes □ no

10. Do you have any suggestions for how your pain management could be improved?

complete page 2 (on back) from chart

PATIENT OUTCOME QUESTIONNAIRE
Page 2

[Faces scale cannot be recreated with current software. You may order this information from the City of Hope Pain Resource Center Index.]

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe		Worst Possible

Medications ordered / administered for this 24 hour period.

Name of Medication*	**Route:** **po** **IM** **IV** **SQ** **PR** **Transdermal / Topical** **Epidural** **Intrathecal**	**Scheduled or PRN**	**How much medication is ordered for the 24 hrs preceding the survey?** **Write orders & calculate the maximum that could be given in the 24 hrs. (e.g. 2-4 mgm q2hrs / 48 mgm)**	**How much medication was given in the 24 hours preceding the survey?**

***MEDICATIONS LIST**

Opioid Agonist:

Fentanyl (Duragesic
Hydromorphone (Dilaudid)
Levorphanol (Levo-Dromoran)
Meperidine (Demeraol)
Methadone (Dolophine, other)
Morphine Sulfate (MS)
MS, controlled release (MS contin, Oramorph)
Oxymorphone (Numorphan)

Combination Opioid / NSAID preparations

Codeine (with aspirin or acetominophen)
Propoxyphene (Darvocet
Hydrocodone (in Lorcet, Lortab, Vicodin, others)
Oxycodone (Roxicodone, also in Percocet, Percodan, Tylox, others)

NSAIDs:

Aspirin
Choline magnesium trisalicylate (Trilisate)
Diflunisal (Dolobid)
Etodolac (Lodine)
Ibuprofen (Motrin, Advil)
Indomethacin (Indocin)
Ketoprofen (Orudis)
Ketorolac tromethamine (Toradol)
Meclofenamate sodium (Meclomen)
Nabumetone (Relafen)
Naproxen (Anaprox, Naprosyn)
Sulindac (Clinoril)

Adjuvants:

Corticosteroids:
- Dexamethasone (Decadron)
- Prednisone

Anticonvulsants
- Carbamazepine (Tegretol)
- Gabapentin (Neurontin)
- Phenytoin (Dilantin)

Antidepressants
- Amitriptyline (Elavil)
- Doxepin (Sinequan)
- Imipramine (Tofranil)
- Mirtazapine (Remevon)
- Trazodone (Desyrel)

Antihistamines
- Hydroxyzine (Atarax, Vistaril)
- Promethazine (Phenergan, Mepergan)

Local Anesthetics / antiarrythmicx
- Lidocaine
- Mexiletine (Mexitil)
- Tocainide (Tonocard)

Psychostimulants
- Dextroamphetamine
- Methylphenidate

Miscellaneous

Acetaminophen (Tylenol)
Butorphanol (Stadol)
Fioricet / Fiorinal
Nalbuphine (Nubain)
Tramadol (Ultram)

CANCER PAIN MANAGEMENT
CHART AUDIT TOOL
St. Luke's Shawnee Mission Health System

Inclusion criteria: Non-surgical cancer patients with diagnosis of:
Primary site of cancer being pancreas, bone, lung / trachea / brochus
Metastatic cancer
Bone Marrow Transplants

Review all pertinent medical records for the day preceding the day of discharge. Review a full 24 hours the day prior to discharge (may use 0001-2400 or 07000-0700 based on documentation forms).

1. MR #:	4. Length of stay (days)
2. Case #:	5. Review done on hospital day number:
3. Admission Date: DC Date:	6. Physician doing primary pain management: Name: #:

7. Patient Population (select one: bone marrow supercedes) ICD-9-CM Code:______________________
   - □ 1) Metastic CA, 196.0 - 198.89
   - □ 2) Primary site: pancreas, 157.0 - 157.9
   - □ 3) Primary site: bone, 170.1 - 170.9
   - □ 4) Primary site: lung, trachea, bronchus: 162.0 - 165.9
   - □ 5) Bone Marrow transplant 41.00 - 41.06

8. Ethnicity: 1) Caucasian, 2) Hispanic, 3) African-American, 4) Asian, 5) American Indian, 6) Other

9. Gender □ Male □ Female	10. Unit: □ Oncology unit □ Non-oncology unit:

11. Is there evidence of the use of a numerical pain rating scale by an ***MD***?
    □ Yes (1) □ No, pain IS documented (2) □ No, pain is NOT documented (3)

12. Is there evidence of the use of a numerical pain rating scale by an ***RN***?
    □ Yes (1) □ No, pain IS documented (2) □ No, pain is NOT documented (3)

13. How many pain ***ratings*** were recorded during this 24 hour period by the RNs?: _________

14. What is the ***highest*** pain rating recorded? __________ □ Not rated

15. What is the ***lowest*** pain rating recorded? __________ □ Not rated

16. What is the ***average*** pain rating (sum of all ratings divided by number of ratings)? __________ □ Not rated

17. Was the patient's goal rating recorded? □ Yes (1) □ No (2)

18. What was the patient's goal? __________ □ Not rated

Analgesic Orders

	Opioid:	Comb Opioid / NSAID	NSAID:	Adjuvant:	Misc:	Bowel Program ordered: (includes medication and / or dietary approaches)
Scheduled	19)	20)	21)	22)	23)	24)
PRN	25)	26)	27)	28)	29)	30)

31. Was Demerol (meperidine) ordered in this 24 hour period? □ Yes □ No
32. Medications ordered / administered for this 24 hour period:

Name of Medication*	Route: po IM IV SQ PR Transdermal / Topical Epidural Intrathecal	Scheduled or PRN	How much medication is ordered for this 24 hour period? Write orders & calculate the maximum that could be given in the 24 hrs. (e.g. 2-4 mgm q2hrs / 48 mgm)	How much medication was given in the 24 hours preceding the survey?

***MEDICATIONS LIST**

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Local Anesthetics / antiarrythmicx
- Lidocaine
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Miscellaneous

Acetaminophen (Tylenol)
Butorphanol (Stadol)
Fioricet / Fiorinal
Nalbuphine (Nubain)
Tramadol (Ultram)

****

Answer the following questions based on review of the entire acute inpatient stay.

33. Was Demerol (meperidine) ordered at any time in this acute inpatient stay? □ Yes □ No

Social Service referral:

34. _____ What day in the stay was a Social Service referral made (admit is day 1)? If Dr. did not order or nursing did not document, enter the day pt was first seen by Social Services. □ No Referral, not seen
35. _____ What day in the stay did Social Services see patient / family? □ No Referral, not seen

Total time required to complete questionnaire: min	Signature of Surveyor:

PAIN ASSESSMENT FLOW SHEET

Pain rating is the rating of pain on the 0-10 scale. Evaluation of interventions may include patient's pain rating or sleeping. See Guidelines on back.
Patient's Goal of pain management is his/her reported acceptable/tolerated level of pain of 0-10 scale. Assess daily.
Interventions: (both pharmacologic and non-pharmacologic - i.e., Heat, massage, cold, relaxation techniques, spiritual assistance, etc.)
Level of Consciousness (LOC) (1) wide awake; (2) drowsy; (3) dozing intermittently; (4) mostly sleeping; (5) only awakens when aroused; (6) non-arousable/comatose

Date	Time	Pain Rating 0-10	Patient's Goal 0-10	L O C	Location of Pain/Symptoms	Interventions Pharmacologic/ Non-Pharmacologic	Re-evaluate Time/Rating		Initials

Signature	Initials	Signature	Initials

PAIN ASSESSMENT FLOW SHEET SHAWNEE MISSION MEDICAL CENTER 9100 W. 74TH STREET SHAWNEE MISSION, KS 66204	

SMMC 60291 (Rev 2/98)

GUIDELINES FOR PAIN ASSESSMENT FLOW SHEET

1. The Pain Assessment Flow Sheet will be initiated for inpatients and outpatients as appropriate.

2. Stamp the Pain Assessment Flow Sheet with the patient's addressograph.

3. The date and time will be filled in for each entry.

4. Assess the current level of pain on the 0-10 scale and document in the appropriate box.

5. The patient's goal for pain relief (on the 0-10 pain scale) will be established and documented in the appropriate box daily.

6. Identify the locatgion and describe any symptoms the patient may report and document them in the appropriate box.

7. In the intervention column, document both pharmacological and non-pharmacological measures taken.

8. Establish the level of consciousness using the numerical key with each intervention and document in the LOC box.

9. Using the pain scale (0-10) document the time of re-evaluation and the outcome of the interventions in the re-evaluation box. Guidelines for re-evaluation time following different routes of administration are:

   a. IV 5-10 minutes
   b. IM 15-30 minutes
   c. PO 45-60 minutes

10. Place initials in the initials box and use the signature key to identify name.

11. RN's will be responsible for documenting on this tool. Other disciplines may also document.

12. When the form is full, a new tool may be initiated.

13. The patient's pain level will be assessed at the beginning of each shift. Once pain is identified, assess every 4 hours or as needed to meet patient's goal.

14. The Pain Assessment Flow Sheet will be kept in the graphic section of the chart as a permanent part of the record.

Expected Outcome:

Eminently dying patient and significant others will experience caring, support, and involvement during dying process with sensitivity to individual needs, differences, and desires. This includes effective pain management, management of any other physical symptoms, psychosocial and spiritual support for both patient and significant others.

Initiation of Protocol:

1. Initiation of protocol will occur after physician, patient and those close to him/her collaborate concerning patient's situation so the intent of palliative care is understood and accepted.
2. Medical orders for DNR status and use of the protocol may then be written.
3. Place copy of protocol on patient's chart and with Kardex.

Initiation of Interventions:

1. Nurse will assess patient and select appropriate interventions from the protocol.
2. Interventions (i.e. medications, oxygen) requiring medical orders can be written by the nurse.
3. A separate medical order needs to be written to initiate MS drip protocol.
4. All medical and nursing orders need to be transcribed to the appropriate forms.

Individual/Family Coping:

1. Provide specific information to patient (if appropriate) and family on expected events prior to death. Give handout "Preparing for Impending Death" or other appropriate information.
2. Keep family informed of patient's vital signs and/or other physiological parameters to help ready them for death.
3. Reassure patient/family that every effort will be made to keep them comfortable throughout the entire dying process.
4. Consult Social Worker to help with identification of risks for dysfunctional grieving and help family and patient resolve any unfinished business.
5. Consult Chaplain for assessment and plans for spiritual support.
6. Encourage family to continue to speak to patient even though patient may be unable to participate.
7. Foster family and patient expression of love, forgiveness and memories.

Pain Management:

1. Obtain order from physician and implement morphine drip protocol as appropriate.
2. Assess patient for urinary retention or urinary incontinence as appropriate. If present, consider use of Foley catheter. If patient experiences no increased agitation with Foley in place, maintain catheter to dependent drainage.
3. Discontinue unnecessary and invasive procedures that can cause discomfort including blood and arterial blood draws, diagnostic X-rays and scans, and fingersticks.
4. Consider use of special mattress/bed as appropriate. (Refer to Special Bed/Mattress Protocol)

Dyspnea Associated With Impaired Gas Exchange and/or Airway Clearance:

1. Position in upright (HOB at 45-90 degrees) or position of comfort.
2. Administer oxygen at 2 liters per nasal cannula (avoid mask if possible) and titrate for comfort up to 5 liters. Obtain oxygen saturation per O_2 oximeter prior to initiation for baseline, then prn after initiation.
3. Place fan in room to provide sensation of circulating air.
4. Ativan 0.5-1mg IV prn for periods of acute respiratory distress.

Approved: Nursing Date _____

Approved: Medical Date _____

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5. Morphine drip protocol may be ordered and initiated periods of dyspnea are uncontrolled by Ativan.
6. Avoid oral or tracheal suctioning unless evidence of copious oral secretions that can be easily removed with gentle oral suctioning.
7. Scopolamine 1.5mg Transdermal Patch for excessive secretions (change every 3 days).

Alterations in Thought Processes:

1. Prepare family for periods of alternating lucidity and/or coma. Explain/give handout to family: "Preparing for Approaching Death" or other appropriate information.
2. Assess occurrences or periods of disorientation in relation to medication. Obtain physician order to discontinue any medication not essential to control other distressing symptoms.
3. Oxygen administered at 2 liters per nasal cannula if disorientation is related to suspected hypoxia.
4. Encourage family to stay at bedside to assure safety, orientation, and emotional security.
5. Provide quiet, bright surroundings in private room and encourage family members to bring in familiar cherished objects.
6. For increased agitation:
   a. Administer ativan 0.5-1.0 mg IV prn or Haldol 0.5-1.0 mg IM if experiencing hallucinations or visual/auditory illusions.

Alterated Mobility, Self Care Deficits & Skin Integrity:

1. Reposition patient every 2 hours unless contraindicated by other symptom management needs.
2. Use special mattresses/beds for skin breakdown or bone metastasis.
3. Encourage family participation in bathing, bed changes and skin care if they desire.Medicate for pain control prior to turning patient, prn.
4. Apply 2% Xylocaine jelly to areas of skin breakdown prior to cleansing or repacking.
5. Tylenol suppository Gr. 10 every 4 hours for temperature elevation over 101 degrees.

Dehydration and Nutrition:

1. Clairfy and support decision of patient/family related to withdrawal of food/fluids.
2. Titrate IV fluids to TKO rate (15 ml/hr) to maintain intact intravenous route for medication administration.
3. Provide oral hygiene every 2 hours. Cleanse mouth with moisture toothettes or Sage "Oraswabs". Lubricate lips with non-petroleum based product (lubra-fax). Allow family members to participate in care as desired.
4. Ice chips prn if patient is able to swallow.

Nausea and Vomiting:

1. For reported nausea or episodes of vomiting:
   a. Compazine suppository 25 mg every 6 hours or Compazine 10 mg IV every 4 hours prn.
2. Limit oral intake to ice chips if patient is alert and able to swallow.
3. Provide mouth care after episodes of vomiting.
4. Eliminate noxious odors and other environmental factors associated with episodes of nausea and vomiting.
5. If vomiting related to partial bowel obstruction, give Reglan 10 mg IV qid.
6. Position patient for comfort on sides or in high fowlers position depending upon other symptoms (dyspnea).

Constipation:

1. Assess bowel function by auscultation, inspection and palpation every shift.
2. For increased bowel sounds and/or bloating, give Dulcolax suppository or Fleets enema prn.
3. Manually removed impacted stool if indicated. Administer pain medication (morphine sulfate 2-4 mg IV) and topical anesthetic (2% Xylocaine jelly as lubricant) prior to removing impaction prn.

Initiated by: ____________________________________

Date: ____

Approved: Nursing Date _____

Approved: Medical Date _____

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Shawnee Mission, IS 66204

Expected Outcome: Patient will demonstrate decrease or absence of signs/symptoms of pain, respiratory distress or restlessness.

Supportive Data: Morphine sulfate may be given by several routes effectively in the majority of patients experiencing pain or respiratory distress. However, patients who have severe pain which is "out of control", patients who cannot tolerate other routes of administration (i.e. loss of G.I. function, unable to take oral meds) or who are eminently terminal may benefit from a continuous infusion of morphine.

Preparation:

Beginning M.S. Drip:

1. Calculate prior narcotic analgesic use and convert to appropriate morphine dose using equianalgesic table **(see reverse side of this page).**
2. Collaborate with physician with above information to obtain ordering parameters.
3. Administer loading dose of morphine slow IV push. Titrate to comfort/effect.
4. Use Abbott PCA pump with continuous plus PCA capability. Use PCA syringe with morphine 1 mg/ml. If patient is on large doses of morphine, consider converting syringe to morphine 5 mg/ml concentration.
5. Begin morphine drip infusion rate per hour at dose calculated with equianalgesic table or prior 24 hr. M.S. IV use. Hold all other narcotics.

Assessment:

1. Monitor pain level using pain flow sheet, BP, heart rate and respiratory rate, level of consciousness and pupil size.
   (Note: pupil size becomes pinpoint with morphine toxicity) every 1 hour x 4; then every 4 hours.

Adjusting M.S. Drip Rate:

1. If respiratory rate falls below 6 per minute or level of consciousness decreases, titrate infusion downward by increments of 1-2 mg. If patient becomes restless, pain increases, or respirations become labored, bolus with morphine 1-2 mg IV and increase IV rate by 1-2 mg increments. May repeat this step every 15 minutes until patient attains comfort or decrease in restlessness.

Toxicity:

For severe toxicity (pupils constricted, respiratory rate below 6 and/or patient not arousable). Determine why patient is getting the drug and collaborate with the Oncology colleagues about treatment. If patient is not eminently terminal, initiate Narcan treatment. **Be cautious with Narcan administration. Titrate gradually until signs and symptoms reverse. Severe pain may result from Narcan administration if not titrated with constant assessment.**

Narcan Tratment:

1. Begin with 0.1 mg Narcan IV push. Observe patient for increase in consciousness and increase in respiratory rate.
2. Re-evaluate every 5-10 minutes for improvements in level of consciousness and respiratory rate.
3. Give additional 0.1 mg Narcan every 5-10 minutes until patient is arousable and respirations above 6 per minute.
4. Notify physician of patient condition.
5. Do not leave bedside until patient is stabilized.

Initiated by: ______________________________

Date: ______________________________

Approved: Nursing Date _____

Approved: Medical Date _____

Shawnee Mission Medical Center
9100 W. 74th Street
Shawnee Mission, KS 66204

Table 10. Dose equivalents for opioid analgesics in opioid-naive adults and children greater than 50 kg body weight

DRUG	APPROXIMATE EQUIANALGESIC DOSE		USUAL STARTING DOSE FOR MODERATE TO SEVERE PAIN	
	Oral	**Parenteral**	**Oral**	**Parenteral**
Opioid agonist (2)				
Morphine	30 mg every 3-4 H (repeat around the clock dosing) 60 mg every 3-4 h (single dose or intermittent dosing)	10 mg every 3-4 h	30 mg every 3-4 h	10 mg every 3-4 h
Morphine, controlled-release (3), (MS Contin, Oramorph)	90-120 mg every 12 h	N/A	90-120 mg every 12 h	N/A
Hydromorphone (3) (Dilaudid)	7.5 mg every 3-4 h	1.5 mg every 3-4 h	6 mg every 3-4 h	1.5 mg every 3-4 h
Levorphanol (Levo Dromoran)	4 mg every 6-8 h	2 mg every 6-8 h	4 mg every 6-8 h	2 mg every 6-8 h
Meperidine (Demerol)	300 mg every 2-3 h	100 mg every 3 h	N/R	100 mg every 3 h
Methadone (Dolophine, other)	20 mg every 6-8 h	10 mg every 6-8 h	20 mg every 6-8 h	10 mg every 6-8 h
Oxymorphone (3) (Numorphan)	N/A	1 mg every 3-4 h	N/A	1 mg every 3-4 h
Combination opioid/NSAID preparations				
Codeine (with aspirin or acetaminophen)	180-200 mg every 3-4 h	130 mg every 3-4 h	60 mg every 3-4 h	60 mg every 2 h (M/SC)
Hydrocodone (in Lorcet, Lortab, Vicodin, others)	30 mg every 3-4 h	N/A	10 mg every 3-4 h	N/A
Oxycodone (Roxicodone, also in Percocet, Percodan, Tylox, others)	30 mg every 3-4 h	N/A	10 mg every 3-h	N/A

1 Caution: Recommended doses do not apply for adult patients with body weight less than 50 kg. For recommended starting doses for children and adults <50 kg body weight, see Table 11 in AHCPR Cancer Pain Management Guidelines, March, 1994.
2 Caution: Recommended doses do not apply to patients with renal or hepatic insufficiency or other conditions affecting drug metabolism and kinetics
3 Caution: For morphine, hydromorphone, and oxymorphone, rectal administration is an alternative route for patients unable to take oral medications. Equinalgesic doses may differ from oral and parenteral doses because of pharmacokinetic differences.