Guideline

Guideline Title: Pain Assessment and Analgesia

Summary: Guideline for ICU staff to ensure that pain is assessed and documented using an appropriate pain scale and that analgesia is administered as per the pain management plan.

Approved by: Director of ICU

Publication (Issue) Date: September 2015

Next Review Date: September 2018

Replaces Existing Policy/ Guideline: Pain assessment and Analgesia

Previous Review Dates: June 2009

Introduction:
The risk addressed by this policy:

Patient safety and patient comfort

The Aims / Expected Outcome of this guideline:

Staff will be able to assess the patient’s pain by using an appropriate pain scale and analgesia will be administered to ensure patient comfort and compliance.

Related Standards or Legislation

- NSQHS Standard 1 Governance
- National Standard 4 Medication Safety

Related Policies

- LH_PD2013_C03.01 Drug Administration
- LH_PD2010_C03.00 Drug Prescribing
- LH_PD2008_C03.12 Administration of IV Medication
- LH_PD2012_C03.05 Accountable Drugs – Schedule 8 (S8) and S4D
- LH_PD2008_C03.29 Patient Controlled Analgesia - PCA
- LH_PD2008_C03.31 Epidural Analgesia – Continuous or Patient Controlled Epi
- ICU Guideline Sedation Management
2. **Policy Statement**

- All care provided within the Liverpool Hospital will be in accordance with infection control guidelines, manual handling guidelines and minimisation and management of aggression guidelines.
- Medications are to be prescribed and signed by a medical officer unless required during an emergency.
- Medications are to be given at the time prescribed and are to be signed by the administering nurse.
  - Parenteral medication prescriptions and the drug are to be checked with a second nurse prior to administration. Adhere to the hospital policy - LH_PD2012_C03.05 Accountable Drugs – Schedule 8 (S8) and S4D
- All drugs administered during an emergency (under the direction of a medical officer) are to be documented during the event, then prescribed and signed following the event.
- Adverse drug reactions are to be documented and reported to a medical officer.
- Medication errors are to be reported using the hospital electronic reporting system: IIMS.
- Guidelines are for adult patients unless otherwise stated.
- Pain score should be assessed every 2-4 hourly for awake and responsive patients using the “Numerical pain score” or the “Faces Pain Scale”. In Patients who are sedated, mechanically ventilated and unresponsive use the “Behavioural Pain Scale” or the Critical-Care Pain Observation Tool (CPOT). This should be documented on the designated section of the ICU flow chart.
- RASS (Richmond Agitation Sedation Scale) must be used to assess sedation scores in all Intensive care patients and documented 2 hourly on the designated section on the ICU flow chart.
- The Pain score and RASS score must be regularly documented by the ICU nurses on the allocated section of the ICU flow chart.

3. **Principles / Guidelines**

**Background**

Patient comfort should be a primary goal of management in the intensive care unit (ICU). This includes adequate pain control, anxiolysis, and prevention and treatment of delirium. However, achieving the appropriate balance of sedation and analgesia is challenging. Analgesic and sedative medications used in ICU have been identified as a risk factor for delirium and prolonged ICU stay. It is important to have rational and agreed upon “target levels” of analgesia and sedation, by all members of the healthcare team.

The prevention and timely treatment of pain for ICU patients is a goal for all ICU clinicians. Appropriate pain assessment and intervention is necessary, as well as taking into account factors that make pain relief problematic – these include age, severity of injury, stage of resuscitation, level of consciousness and medical stability.\(^1\) In the ICU, researchers have found that patients are often unable to communicate their pain, they recall having pain but often do not understand why and this is associated with anxiety over loss of control.\(^3,10\)

Pain may be a protective mechanism to avoid or warn of damage; its experience differs between individuals. The International Association for the Study of Pain (IASP) defines it as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage”.

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\(^1\)\(^2\)\(^3\)\(^10\)
ICU clinicians must assess pain or the potential for it, develop an appropriate pain relief strategy and evaluate and document the effectiveness of this pain management strategy.¹

**Pain Assessment Scales:**
There are various available pain scales.

**For Awake and Non-Mechanically Ventilated patients:** The Numerical Rating Scale (NRS) (1 to 10) and the Faces Pain Scale (0 to 10) have been validated for acute pain only and not in mechanically ventilated patients in the ICU²¹. They can be used for the awake patients in ICU who can self report their pain. Patient relatives may also be involved in the assessment of pain.

**For Unresponsive and Mechanically Ventilated Patients:** For those patients that are unable to self-report, the *Behavioural Pain Scale* (BPS) and the *Critical-Care Pain Observation Tool* (CPOT) are the most valid and reliable behavioural pain scales for monitoring pain in adult ICU patients. These scales were developed specifically for measuring the severity of pain in sedated, mechanically ventilated, unresponsive patients²³.

Assess Pain Scale every 2-4 hours. Self-reporting of pain should be used whenever appropriate.

Numerical Rating Scale and Faces Pain Scale - If pain score < 4, consider analgesia effective, reassess frequently as ongoing analgesia may need to continue. If pain score ≥ 4, increase analgesia to relieve pain.

Patient is in significant pain if BPS > 5; CPOT > 3, administer appropriate analgesia.

In Liverpool ICU the NRS is used for awake responsive patient and the CPOT is used for sedated and mechanically ventilated patients.

**Process for assessing pain**
- Pain Assessment – is a process of information gathering to obtain an overall picture of the patient’s pain and variables affecting the pain.
- Assessment of pain in its entirety includes not only intensity of pain and response to treatment, it also includes a detailed pain history (site, quality, aggravating and relieving factors and pre-existing pain conditions).
- The intensity of pain or discomfort is assessed using a pain scale and documented on the ICU flowchart upon:
  - Admission
  - After any known procedure that may produce pain.
  - With each new report of pain
  - At regular intervals, depending upon the severity of pain,
  - Routinely at 2-4 hourly assessment intervals; or more frequently

- Prior to known or suspected painful procedures, analgesia is administered to prevent or decrease the degree of pain and anxiety felt by the patient. This is in conjunction with review of previously administered analgesia and sedation, their effect on the patient and the patient’s vital signs.
- The medication chart and IV infusion prescriptions are reviewed to ensure that pain-relieving medication and sedative prescriptions are appropriate, timing of doses is interspersed and that the chart and Schedule 8 / Schedule 4D drug registers document the administration of these prescribed drugs.
- Nausea, vomiting, itching and constipation need to be assessed and managed appropriately.
- Determining if the analgesia has been effective:
  - The patient is able to deep breathe and cough easily
Respiratory function is improved
Mobilisation without guarding occurs

Pain Management Strategies

There are a variety of analgesics that can be used to manage pain. It is important to have endpoints that are being used to titrate analgesia. The recommendations as per the Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit (Barr, Fraser et al, 2013) are:

- Opioids should be considered as the first-line drug class of choice to treat non-neuropathic pain in critically ill patients. All available IV opioids, when titrated to similar pain intensity endpoints, are equally effective.
- Enterally administered gabapentin or carbamazepine, in addition to IV opioids, should be considered for the treatment of neuropathic pain.
- Non-opioid analgesics should be considered to decrease the amount of opioids administered (or to eliminate the need for IV opioids altogether) and to decrease opioid-related side effects.

The majority of pain managed in ICU is regarded as acute pain – defined as occurring within 6 months of onset. Patients with chronic pain or acute on chronic pain will have a combined ICU and Acute/Chronic Pain Service approach. Patients with a history of illicit drug use (requiring larger doses of analgesia to effect pain relief) will have an ICU and Drug and Alcohol team approach to manage pain effectively.

Therapy for Pain

Non-Pharmacological Management:
- Establishing a method of nonverbal communication (eg: blinking or head nodding)
- Use a calm voice and gentle touch to convey reassurance.
- Frequent repositioning and ensuring patients are comfortably positioned.
- Ensure basic hygiene needs attended –such as brushing teeth, washing the patient, attending skin care.
- Using diversion therapy– getting family to speak to patient, encouraging them to listen to music, re-orientating them, mobilising them.
- Ensure adequate lighting, reducing the level of noise in the environment.
- Cognitive – behavioral strategies.

Pharmacological Management
- Opioids: Fentanyl and morphine are the most commonly used opioid infusions. Pethidine (very rarely used), oxycodone and codeine are some of the other opioids that can be administered for analgesia. Fentanyl should be used for patients with renal insufficiency.
- Paracetamol – may be used in addition to opioids or to wean patient off intravenous analgesic infusions.
- Anticonvulsants such as gabapentin or carbamazepine should be used for the control of neuropathic pain.
- Ketamine
- Peripheral nerve block with local / regional anesthetic agents.
- Epidural analgesia
- PCA (patient controlled analgesia) usually with opioids for patients able to use the pain button.
Precautions:
- Multimodal analgesia may be used to manage pain appropriately (use of paracetamol, morphine and NSAIDS) and a plan of care should be established for those patients whose pain is difficult to manage.
- Appropriate determination of the acuity of the patient and best placement to receive care; observation and assessment of the patient must be considered when using large volumes of analgesia to treat resistant pain.

Clinical Issues:
- In patients with a brain injury (SAH, ICH, SDH, stroke) and those patients who may require, or who have had, neurosurgery, consider the following:
  - The use of opioids may cause sedation, miosis (pupil constriction) and may mask signs of neurological deterioration.\(^6,9\)
  - Opioids may decrease minute ventilation leading to hypercapnoea, increased intracerebral blood volume, seizures and cerebral oedema.\(^6,7\)
  - Tramadol should generally be avoided due to its propensity to induce nausea and vomiting, and the (slight) risk of inducing seizures.\(^8\)
  - Ketamine is avoided as it may increase intracranial pressure.\(^12\)
- In patients post trauma requiring pain relief:
  - Traumatic injuries increase the stress response, more so than elective surgery associated pain.\(^12\)
  - Analgesia choice and the use of multimodal analgesic agents may assist in preventing immuno-suppression, hyperglycaemia, catabolic response and decreased post-traumatic stress disorder.\(^12\)
  - Pre-emptive analgesia (in all patients with pain-inducing procedures, movement, injury) may reduce acute and chronic pain.\(^12\)
- Where the patient may be heavily sedated and the ‘Behavioural Assessment of Pain Scale’ may be less reliable, consider administering analgesia in the event of:\(^10\)
  - Recent surgical wounds
  - The presence of drains and tubes, including tracheostomy tube
  - Fractured bones, abdominal pathology
  - Physiotherapy, suctioning, mobilising/turning
  - Increased sedation requirements may also indicate inadequate analgesia.
- Sedation of patients does not address pain. Neuromuscular blockers (paralysing agents) do not sedate or provide analgesia.
- Where a prescription for an opioid is written with a range of doses stated to meet changing levels of pain: e.g. morphine, 2-10mg IV every 4 hours prn for pain:
  - Assess pain, location, causes, previous pain relief administered and effect
  - Review drug time to onset, time to peak effect and general duration
  - Verify any adverse drug reactions/allergies
  - In opioid naïve patients (those patients who have not had opioids before, or rarely) who have a dose range prescription as above, and their pain is not excruciating - give initial lowest dose of 2 mg IV, assess effect; if adequate, reassess in 1-2 hours. If no side effects but inadequate relief, increase the dose as per the prescribed prn dose.\(^13\)
  - Where there are side effects or limited pain relief, consult with the MO and develop a pain management plan.
  - Side effects of opioids are often dose related.\(^14\)
- Medications that are commonly confused:
Oxycodone may be a slow release preparation (Oxycontin – where the 'contin' stands for 'continuous'); or it may be an immediate release preparation, such as Endone, (remembered by thinking of it as 'end it now'). Consequently, prescribing this drug using the generic name requires the prescriber to state SL for slow release or else the medication will be dispensed in its immediate release form.

MSContin: the MS is an abbreviation used for 'morphine sulphate' and the 'contin' again refers to a 'continuous' slow release formulation.

The nurse administering the drug must be aware of the drug differences and for what intensity of pain the drug is being used for and the duration of effect that the drug has.

Other issues include whether a drug is suitable for administration via a nasogastric tube; preferably the liquid form of the drug should be used. Crushing a slow release tablet will render it an immediate release drug, which may have respiratory, cardiac and neurological consequences for the patient.

When administering drugs that are combined preparations, use caution that other prescriptions for the patient do not include those drugs; e.g. patients receiving IV paracetamol should not then receive other combination drugs that also have paracetamol included.

Careful documentation of pain assessment and the patient's response to administered analgesics must be made on the ICU Flowchart or in the health care record. Complimentary methods used to diminish pain are to be documented. Education regarding pain and the use of analgesics are to be documented in the health care record.

Inadequate pain-relief issues:

- Poor pain control can lead to adverse outcomes including respiratory and thromboembolic problems, reduced mobility, increased length of stay and decreased quality of life.\(^2\) Catabolism, immunosuppression and prolonged maintenance of the sympathetic response occur in acute, uncontrolled pain; resulting in hypertension, tachycardia, myocardial ischaemia and the stress response.\(^11\)

- Failure to adequately treat acute pain may result in issues of chronic pain.\(^2,11\)

4. Performance Measures

All incidents are documented using the hospital electronic reporting system: IIMS and managed appropriately by the NUM and staff as directed.

5. References / Links


20. MIMS Online, CIAP: NSW Health Department, Copyright MIMS Australia Pty Ltd 2013. [http://www.mims.hcn.net.au/](http://www.mims.hcn.net.au/)


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Reviewers: Director-ICU, ICU – Staff Specialists, NM, CNE’s, CNS’s, Pharmacists.

Endorsed by: A/Prof M. Parr, Director- ICU
Appendix 1 - Sedation score

Instructions
- Obtain a sedation score goal at handover/ward round; document this in the health care record (either in the clinical notes or on the ICU flowchart CR145).
- Assess a sedation score and a Glasgow Coma Score (GCS) at least every 2 hours and as clinically indicated (some patients may require hourly assessment of GCS). Note that if a stable patient is prescribed a sedative to assist with sleeping (e.g. temazepam) it is reasonable to omit one episode of assessment.
- Conduct a sedation score even if there is no apparent drug in use that would contribute to sedation; if sedation is present and not a goal of therapy – report this to the M.O. and document findings, action plan and outcome in the health care record.
- A ‘sedation – vacation’ from sedative drugs must be prescribed when the sedation score is deemed ‘moderate sedation: ‘- 3’, and this degree of sedation is not the goal of therapy.

Assessment
The use of a sedative aims to:
- enable the patient to cooperate with ventilation and treatments, and
- produce a desired amnesia to the Intensive Care environment.
- document which drugs the patient is taking to produce a sedative effect

Richmond Agitation-Sedation Score (RASS)\(^{16}\)

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

Procedure
- Observe patient
  - Patient is alert, restless or agitated (score 0 to + 4)
- If not alert, state patient’s name and say to open eyes and look at speaker (score − 1)
  - Patient awakens with sustained eye opening and eye contact
  - 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)
- When no response to verbal stimulation, physically stimulate the patient by shaking shoulder and / or using the trapezius pinch or applying supra-orbital pressure, as appropriate
  - Patient has any movement to physical stimulation (score − 4)
  - Patient has no response to any stimulation (score − 5)
APPENDIX 2: Pain Assessment

_Awake and responsive:_

Use "Faces Pain Scale - Revised" adapted for ICU - get the patient to point to the face that matches their pain level or ask the patient: 0 = none, 5 = worst pain.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No pain</td>
</tr>
<tr>
<td>2</td>
<td>Mild pain, discomfort only with moving</td>
</tr>
<tr>
<td>4</td>
<td>Continuous mild pain</td>
</tr>
<tr>
<td>6</td>
<td>Continuous moderate pain</td>
</tr>
<tr>
<td>8</td>
<td>Continuous severe pain</td>
</tr>
<tr>
<td>10</td>
<td>Excruciating pain</td>
</tr>
</tbody>
</table>

Assess for pain at least every 4 hours:

- If pain score < 4, consider analgesia effective, reassess frequently as ongoing analgesia may need to continue.
- If pain score ≥ 4, increase analgesia to relieve pain.
- Maintain prescribed sedation score, report any issues to the M.O. and document.
- Document score on the flowchart.
- If the patient has no pain and they are able to cough easily, deep breathe and move easily, the ongoing need for analgesia is assessed.

_Patients who are sedated, mechanically ventilated and unresponsive_

Use the “Behavioural Pain Scale” or the Critical-Care Pain Observation Tool (CPOT)

<table>
<thead>
<tr>
<th>ITEM</th>
<th>DESCRIPTION</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial Expression</td>
<td>Relaxed</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Partially tightened (eg, brow lowering)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fully tightened (eg, eyelid closing)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Grimacing</td>
<td>4</td>
</tr>
<tr>
<td>Upper Limb Movements</td>
<td>No movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Partially bent</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fully bent with finger flexion</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Permanently retracted</td>
<td>4</td>
</tr>
<tr>
<td>Compliance with mechanical ventilation</td>
<td>Tolerating movement</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Coughing but tolerating ventilation for most of the time</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fighting ventilator</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Unable to control ventilation</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTAL SCORE 3 TO 12**

Score ranges from 3 (no pain) to 12 (maximum pain).
The Critical-Care Pain Observation Tool (CPOT)\textsuperscript{11}.

Directives of use of the CPOT

1. The patient must be observed at rest for one minute to obtain a baseline value of the CPOT.
2. Then, the patient should be observed during nociceptive procedures (e.g. turning, wound care) to detect any changes in the patient's behaviours to pain.
3. The patient should be evaluated before and at the peak effect of an analgesic agent to assess whether the treatment was effective or not in relieving pain.
4. For the rating of the CPOT, the patient should be attributed the highest score observed during the observation period.
5. The patient should be attributed a score for each behaviour included in the CPOT and muscle tension should be evaluated last, especially when the patient is at rest because the stimulation of touch alone (when performing passive flexion and extension of the arm) may lead to behavioural reactions.

Observation of patient at rest (baseline).

The nurse looks at the patient's face and body to note any visible reactions for an observation period of one minute. She gives a score for all items except for muscle tension. At the end of the one-minute period, the nurse holds the patient's arm in both hands – one at the elbow, and uses the other one to hold the patient's hand. Then, she performs a passive flexion and extension of the upper limb, and feels any resistance the patient may exhibit. If the movements are performed easily, the patient is found to be relaxed with no resistance (score 0). If the movements can still be performed but with more strength, then it is concluded that the patient is showing resistance to movements (score 1). Finally, if the nurse cannot complete the movements, strong resistance is felt (score 2). This can be observed in patients who are spastic.

Observation of patient during turning.

Even during the turning procedure, the nurse can still assess the patient's pain. While she is turning the patient on one side, she looks at the patient's face to note any reactions such as frowning or grimacing. These reactions may be brief or can last longer. The nurse also looks out for body movements. For instance, she looks for protective movements like the patient trying to reach or touching the pain site (e.g. surgical incision, injury site). In the mechanically ventilated patient, she pays attention to alarms and if they stop spontaneously or require that she intervenes (e.g. reassurance, administering medication). According to muscle tension, the nurse can feel if the patient is resisting to the movement or not. A score 2 is given when the patient is resisting against the movement and attempts to get on his/her back.
## The Critical-Care Pain Observation Tool (CPOT)

(Gelinas et al., 2006)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial expression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed, neutral</td>
<td>0</td>
<td>No muscle tension observed</td>
</tr>
<tr>
<td>Tense</td>
<td>1</td>
<td>Presence of frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during receptive procedures)</td>
</tr>
<tr>
<td>Grimacing</td>
<td>2</td>
<td>All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or being the endotracheal tube)</td>
</tr>
<tr>
<td>Body movement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of movement or normal position</td>
<td>0</td>
<td>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)</td>
</tr>
<tr>
<td>Protest</td>
<td>1</td>
<td>Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements</td>
</tr>
<tr>
<td>Restlessness/Agitation</td>
<td>2</td>
<td>Pulling tube, attempting to sit up, moving limbs, thrashing, not following commands, striking at staff, trying to climb out of bed</td>
</tr>
<tr>
<td>Compliance with the ventilator (intubated patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerating ventilator or movement</td>
<td>0</td>
<td>Alarms not activated, easy ventilation</td>
</tr>
<tr>
<td>Coughing but tolerating</td>
<td>1</td>
<td>Coughing, alarms may be activated but stop spontaneously</td>
</tr>
<tr>
<td>Fighting ventilator</td>
<td>2</td>
<td>Asynchrony: blocking ventilation, alarms frequently activated</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocalization (extubated patients)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking in normal tone or no sound</td>
<td>0</td>
<td>Talking in normal tone or no sound</td>
</tr>
<tr>
<td>Sighing, moaning</td>
<td>1</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td>Crying out, sobbing</td>
<td>2</td>
<td>Crying out sobbing</td>
</tr>
<tr>
<td>Muscle tension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed</td>
<td>0</td>
<td>No resistance to passive movements</td>
</tr>
<tr>
<td>Tense, rigid</td>
<td>1</td>
<td>Resistance to passive movements</td>
</tr>
<tr>
<td>Very tense or rigid</td>
<td>2</td>
<td>Strong resistance to passive movements or incapacity to complete them</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Assess Pain Scale every 2-4 hours. Self-reporting of pain should be used whenever appropriate.

Patient is in significant pain if BPS > 5; CPOT > 3
APPENDIX 3:

1. **Assess Analgesia**

   - In pain?
     - Yes: Fentanyl 10-50 micrograms/hr OR Morphine 1-5 mg/hr
     - No: Reassess often (2-4 hourly)

2. **Assess Sedation**

   - RASS at Target? (usual is -1 to 0)
     - No: Consider daily sedation vacation & Spontaneous breathing trial
     - Yes: Reassess and document 2nd hourly
     - Under-Sedated:
       - Hold sedative/analgesic to achieve RASS target. Restart at 50% of the rate it was running at.
     - Over-Sedated:
       - 1. Propofol 5-10 ml/hr (50 to 100 mg/hr).
       - 2. Dexmedetomidine 0.20 to 0.7 mcg/kg/hr (if weaning off sedation or ventilation).
       - 3. Midazolam 1-3 mg/hr (only use if patient is in alcohol withdrawal or has propofol intolerance, this is because use of benzodiazepines has been associated with an increased incidence of delirium)

3. **Assess Delirium**

   - If RASS ≥ 3 perform CAM-ICU Delirium Assessment
     - Negative: Reassess in 12 hrs
     - Positive:
       - Non-pharmacological management
       - Pharmacological management (as per delirium guideline)