1. APMS PAIN ASSESSMENT: Approach to APMS pain assessment for a floor patient (i.e. with epidural, a block catheter, or IV-PCA)

Standard Tasks for APMS Patient Review:
- Anesthetic record
- Surgical record
- Blood loss and blood products
- Recent labs
- Progress notes from Surgery (NPO? NGT? Estimated LOS?
- Notes from nursing
- Notes from APMS (on ACUPAM) (plan from previous day, changes made, trends with pain and clinical course)

GOALS for each floor patient assessed to keep in mind throughout your assessment:

1. **Analgesia** – is their pain manageable? Scale of 0/10.
    a. 0 is no pain
    b. 4 is uncomfortable
    c. 6 is distressing
    d. 10 is excruciating
2. **Function** – is their pain impacting their function?
    a. Ambulation ok? Or able to transfer from bed to chair? Or able to reposition themselves in bed comfortably?
    b. Sleeping ok?
    c. Too sleepy? I.e. Oversedation from pain medication.
    d. Pain with deep breaths? Are they visibly splinting? Are they about to cough comfortably?
3. **Side effects** – is the pain medication causing uncomfortable side effects?
    a. Nausea
    b. Vomiting
    c. Pruritus
    d. Sedation
    e. Dizziness or presyncopal symptoms

2. PAIN MEDICATION ACTIVITY: Case stem for medication order activity with pain staff/NP

Please complete the following activity on a green medication order sheet and review it with the APMS staff or Nurse Practitioner:

CASE STEM: You are a PGY1 resident on your general surgery rotation. Please write out appropriate multimodal pain orders, including adjuncts for side effects from the pain medications, for a 48 yo patient who just underwent a laparoscopic cholecystectomy and who is being admitted to the floor overnight. They are an otherwise healthy person with no known drug allergies.

3. GENERAL PAIN CONSULT TEMPLATE

HPI:

- OPQRST of pain:

Onset	When did it start? Acute or gradual? What were you doing?
Provoking/palliating	What makes it feel better? What makes it worse?
Quality	What does it feel like (ie. dull, sharp, burning, throbbing etc)
Region/Radiation	Where is the pain? Does pain move? Where does it start/end?
Severity	NRS 0-10/10 where 0 is no pain, 4 is uncomfortable, 6 is distressing, 10 is excruciating Does patient live chronically with pain? If so, what is pain score on a good day? Bad day?
Time	Is pain constant? Intermittant? Is there a predictable pattern?
Understanding	Elicit patient's understanding/concerns about pain and pain management

Treatment: Are the medications working? What works best for patient?
Medications – pain medications (home/hospital)/mood & sleep/anticoagulants/antiplatelets

- Calculate opioid use over 24 hours

Side effects from medications: N+V, lightheadedness, systemic pruritus etc.
Baseline Function/Current function – Does pain prevent mobilizing, taking a deep breath etc, Are meds improving function?
Imaging results if pertinent:
PmHx / Surgeries: If treated place medication in brackets beside condition ie. HTN (Valsartan), previous PE (Plavix) etc
Lab values: CBC, INR/PTT, Electrolytes (creatinine, eGFR)/ Magnesium
Physical examination including vital signs: Assess area of pain (any red flags?)
Impression: type of pain (somatic, visceral, neuropathic? Mixed nociception?)/ cognitive/emotional factors that might influence pain
Plan: To be discussed with APMS group