Pain management

Pain management

Revised: May 19, 2025

Introduction

Pain is the sensory and emotional experience associated with actual or potential tissue damage. It includes not only the patient's perception of an uncomfortable stimulus but also the response to that perception.[1]

The patient's report of pain is the most reliable indicator of the existence of pain.[2][3] With severe pain, a patient commonly seeks medical help for pain relief and may believe that the pain signals a serious problem. This perception produces anxiety, which in turn can increase the pain. Assessing and managing pain requires listening to the patient's subjective description of the pain and using objective tools.

Each facility should have defined criteria to screen for, assess, and reassess a patient's pain that are consistent with the patient's age, condition, and ability to understand.[4] Pain assessment should include personal, cultural, spiritual, and ethnic beliefs. Nurses must educate patients and families about their role in pain management and inform them of the potential limitations and adverse effects of pain treatment. To evaluate progress toward pain management goals, pain should be reassessed at designated intervals according to the type of pain intervention (for example, whether pain medication was administered by the oral, IV, or transdermal route).[4]

Interventions nurses can use to manage pain include administering analgesics, providing emotional support or comfort measures, and using complementary and alternative therapies, such as cognitive techniques to distract the patient (breathing relaxation techniques or imagery) or Reiki or aromatherapy to promote relaxation. Severe pain usually requires administration of an opioid analgesic. Invasive measures, such as epidural analgesia or patient-controlled analgesia (PCA), may also be necessary.[5]

Equipment

- Facility-approved pain assessment tool
- Glass or cup of fresh water
- Oral care supplies
- Prescribed pain medication
- Soap
- Washcloth and towel
- Water
- Optional: capnography equipment, cold compresses, PCA device, pillow, pulse oximeter and probe, radio or other device for listening to music, sedation scale

Preparation of Equipment

Inspect all equipment and supplies. If a product is expired, is defective, or has compromised integrity, remove it from patient use, label it as expired or defective, and report the expiration or defect as directed by your facility.

Implementation

- Review the patient's medical record for the patient's current clinical condition, past medical history, and pain management goals when available.[4]
- Review the patient's pain history, including previous use or abuse of analgesics, possible adverse effects associated with potential opioid tolerance or intolerance, and previous pain level when available.[6]
- Perform hand hygiene.[7][8][9][10][11][12]
- Confirm the patient's identity using at least two patient identifiers.[13]
- Provide privacy.[14][15][16][17]
- Obtain the assistance of a medical interpreter as necessary.[18][19]
- Raise the bed to waist level before providing care *to prevent caregiver back strain.*[20]
- Perform hand hygiene.[7][8][9][10][11][12]
- Screen for and assess the patient's pain using facility-defined criteria that are consistent with the patient's age, condition, and ability to understand.[4] As directed, use a facility-approved pain assessment tool or scale. (See the "Pain assessment" procedure.)
- Ask key questions and note the patient's response.[4] For example, ask the patient to describe the pain's duration, severity, and location. Look for physiologic or behavioral clues to the pain's severity.[5] (See *How to assess pain*.)

HOW TO ASSESS PAIN

To assess pain properly, consider both the patient's description and your observations of the patient's physical and behavioral responses. A comprehensive, culturally sensitive pain assessment tool should capture the effects of cultural norms on the patient's pain experiences, examine the meaning that the pain has to the patient, and help determine the patient's treatment preferences (such as herbs, home remedies, complementary therapies, or the services of alternative or cultural healers).[18]

Start by asking the following questions (bearing in mind that the responses will be shaped by the patient's experiences, self-image, culture, and beliefs about the condition):

- Where is the pain located? How long does it last? How often does it occur?
- How would you describe the pain?
- What brings the pain on?
- What relieves the pain or makes it worse?
- What do you think is causing your pain?
- What do you fear most about the pain?
- What problems does the pain cause you?
- Who else have you consulted about the pain? Family members? A traditional healer?
- What treatments do you think might help you with the pain?

Ask the patient to rank the pain on a scale from 0 to 10, with 0 indicating no pain and 10 indicating the worst pain possible. Establish with the patient what would be considered a low pain level (usually 4 or lower on a 0-to-10 scale).

Observe the patient's behavioral and physiologic (sympathetic or parasympathetic) responses to pain.

Behavioral responses

Behavioral responses include altered body position, moaning, sighing, grimacing, withdrawal, crying, restlessness, muscle twitching, and immobility.

Sympathetic responses

Sympathetic responses are commonly associated with mild to moderate pain and include pallor, elevated blood pressure, dilated pupils, skeletal muscle tension, dyspnea, tachycardia, and diaphoresis.

Parasympathetic responses

Parasympathetic responses are commonly associated with severe, deep pain and include pallor, decreased blood pressure, bradycardia, nausea, vomiting, weakness, dizziness, and loss of consciousness.

- In collaboration with the multidisciplinary team, involve the patient in the pain management planning process. Provide education on pain management, treatment options, and the safe use of opioid and nonopioid medications (when prescribed). Develop realistic expectations and measurable goals related to the degree, duration, and reduction of pain that the patient understands. Discuss objectives for evaluating treatment progress (for example, relief of pain and improved physical and psychosocial function).[4]
- Treat the patient's pain, as needed and ordered, using nonpharmacologic, pharmacologic, or a combination of approaches. Base the treatment plan on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.[4]

Providing emotional support

- Show your concern by spending time talking with the patient. *Because of the pain and the inability to manage it,* the patient may be anxious and frustrated. *Such feelings can worsen the pain.*
- Assess the patient's spiritual and cultural needs and incorporate spiritual and cultural practices as desired by the patient.[1] (See the "Cultural assessment" procedure.)

Providing comfort

- Perform hand hygiene.[7][8][9][10][11][12]
- Reposition the patient periodically *to reduce muscle spasms and tension and to relieve pressure on bony prominences*. Increasing the angle of the bed can reduce pull on an abdominal incision, *which can diminish pain.* If appropriate, elevate a limb *to reduce swelling, inflammation, and pain.*
- Encourage the patient to splint or support abdominal or chest incisions with a pillow when coughing or changing positions *to help decrease pain.*
- Apply cold compresses as appropriate *to decrease discomfort.*[5]
- Give the patient a back massage *to reduce muscle tension.*[5]
- Perform passive range-of-motion exercises *to prevent stiffness and further loss of mobility, relax tense muscles, and provide comfort.* (See the "Passive range-of-motion exercises" procedure.)

- Provide oral care. (See the "Oral care" procedure.) Keep a glass or cup of fresh water at the patient's bedside *because many pain medications dry out the mouth.*
- Wash the patient's face and hands using a washcloth and towel *to soothe the patient, which may reduce the perception of pain.*

Using complementary and alternative therapies

- Help the patient enhance the effect of analgesics by using complementary and alternative therapies, such as distraction, guided imagery, deep breathing, music therapy, muscle relaxation, and visual concentration and rhythmic massage.[5] Choose the method based on the patient's preference. If possible, start these techniques when the patient feels little or no pain. If the patient feels persistent pain, begin with short, simple exercises. Before beginning, dim the lights, help the patient loosen or remove restrictive clothing, and eliminate noise from the environment.
  - For distraction, have the patient recall a pleasant experience or focus attention on an enjoyable activity. Note, however, that distraction is usually only helpful in relieving pain that lasts for a short period or during painful procedures of short duration.[6]
  - For imagery, help the patient concentrate on a peaceful, pleasant image such as walking on a beach. Encourage the patient to concentrate on the details of that image by asking about the associated sights, sounds, smells, tastes, and touch. *The positive emotions evoked by this exercise minimize pain.*[6]
  - For deep breathing, have the patient focus on an object and then slowly inhale and exhale while focusing on maintaining a comfortable rate and rhythm. Have the patient concentrate on the rise and fall of the abdomen. Encourage the patient to imagine feeling increasingly lighter with each breath while concentrating on the rhythm of the breathing or a restful image.[6]
  - For music therapy, play the patient's preferred music. Consult with a music therapist if available. *Music therapy has been associated with a statistically significant reduction in opioid and nonopioid analgesic use.*[21] [22]
  - For muscle relaxation, have the patient focus on a particular muscle group. Then ask the patient to tense the muscles and note the sensation. After 5 to 7 seconds, tell the patient to relax the muscles and to concentrate on the relaxed state. Have the patient note the difference between the tensed and relaxed states. Then proceed to another muscle group until you've covered the entire body.[6]
  - For visual concentration and rhythmic massage, have the patient stare at an object or close the eyes and think of a peaceful, calm scene. Then instruct the patient to firmly massage the area near the painful body part using a circular motion with the palm of the hand. Tell the patient to avoid any red or swollen areas. A family member or friend can perform the massage as well.[6]

Giving medication

- Perform hand hygiene.[7] [8] [9] [10] [11] [12]
- If the patient's condition permits oral medications, begin with a nonopioid analgesic, such as acetaminophen or a nonsteroidal anti-inflammatory drug (NSAID) as ordered following safe medication administration practices.[23] [24] [25] [26] [27]
- If the patient needs more relief than a nonopioid analgesic provides, administer a mild opioid (such as tramadol or codeine) as ordered following safe medication administration practices.[23] [24] [25] [26] [27]

- If the patient needs still more pain relief, administer a strong opioid (such as morphine, oxyCODONE, or HYDROmorphone) as ordered (oral medications if possible) following safe medication administration practices.[23] [24] [25] [26] [27]
- For the patient receiving IV opioid medication, follow these steps:
  - Monitor closely if the patient is at high risk for adverse outcomes related to opioid treatment.[4] Frequently monitor the patient's respiratory rate, oxygen saturation level by pulse oximetry, end-tidal carbon dioxide level by capnography (if available), and sedation level using a standardized sedation scale *to decrease the risk of adverse events associated with IV opioid use.* (See *Pasero opioid-induced sedation scale*.)[28]
  - Explain the assessment and monitoring process to the patient and family according to their communication and learning needs *to increase their understanding, allay their fears, and enhance cooperation.*[19] Tell them to alert a staff member if breathing problems or other changes occur that might be a reaction to the medication.[28]

PASERO OPIOID-INDUCED SEDATION SCALE

The Pasero opioid-induced sedation scale is a valid, reliable sedation scale used to assess sedation during opioid use for pain management.[29] The scale provides nursing interventions for various levels of sedation that may include increasing the opioid dose in a patient who's easily aroused but reports unacceptable pain relief or decreasing or holding a dose in a patient who's overly sedated. The practitioner's opioid order or facility protocol should permit you to decrease the dose if the patient is overly sedated. When performing an assessment, keep in mind that even a sedated patient may arouse when approached or touched. *To properly assess sedation,* observe how quickly the patient arouses and answers a simple question. The patient who arouses easily should be able to answer the question completely without falling back to sleep.

Scale	Nursing interventions
S = Sleep, easy to arouse	Acceptable; no action necessary; may increase opioid dose if necessary (if permitted by order or protocol)
1. Awake and alert	Acceptable; no action necessary; may increase opioid dose if necessary (if permitted by order or protocol)
2. Slightly drowsy, easily aroused	Acceptable; no action necessary; may increase opioid dose if necessary (if permitted by order or protocol)
3. Frequently drowsy, arousable, drifts off to sleep during conversation	Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose by 25% to 50% (if permitted by order or protocol), or notify the practitioner or anesthesiologist for orders; consider administering a nonsedating, opioid-sparing nonopioid, such as acetaminophen or a nonsteroidal anti-inflammatory drug, if not contraindicated
4. Somnolent, minimal or no response to verbal or physical stimulation	Unacceptable; stop opioid use; consider administering naloxone (if permitted by order or protocol); notify the practitioner; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory

- If ordered, teach the patient to use a PCA device, which can help manage pain and decrease anxiety. (See the "Patient-controlled analgesia" procedure.)

Completing the procedure

- Reassess and respond to the patient's pain by evaluating the response to treatment and progress toward pain management goals. Assess for adverse reactions and risk factors for adverse events that may result from treatment.[4]
- Return the bed to the lowest position *to prevent falls and maintain the patient's safety.*[30]
- Perform hand hygiene.[7] [8] [9] [10] [11] [12]
- Document the procedure.[31] [32] [33] [34]

Special Considerations

- During periods of intense pain, the patient's ability to concentrate diminishes. In the case of severe pain, help the patient select a cognitive technique that's easy to use and then encourage its consistent use. Remind the patient that the results of cognitive techniques improve with practice. Help the patient through the initial sessions.
- You shouldn't consider pain to be a normal part of the aging process. Use pharmacologic and nonpharmacologic approaches to provide pain relief for older adult patients. Keep in mind that safety is a special concern, with an increased risk of falling because of impaired mobility from pain and adverse effects of pain medications.[35]
- Identify age-related factors that can affect assessment and pain management in older adult patients.[35]

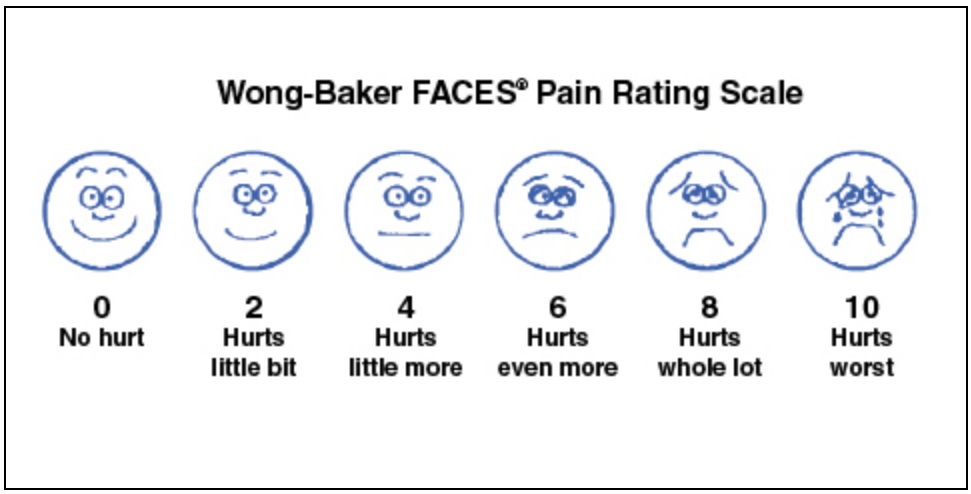
◆ ***Older adult alert:*** *Because of the potential for adverse effects,* avoid using certain medications (such as meperidine and methadone) and prolonged use of NSAIDs in older adult patients.[36] [37] ◆

- Encourage cultural remedies for pain, such as the involvement of extended family and the use of complementary therapies such as acupuncture. *Research indicates that family support improves patient outcomes and that acupuncture can be effective in managing pain.*[18]
- The U.S. Food and Drug Administration requires the addition of a boxed warning to the prescribing information for all opioid drugs, advising that the patient not stop taking opioids abruptly. Opioids should be withdrawn slowly, according to an individualized, gradual taper plan *to prevent signs and symptoms of withdrawal, worsening of pain, and psychological distress in physically dependent patients.* Refer to the Centers for Disease Control and Prevention's (CDC's) "CDC clinical practice guideline for prescribing opioids for pain—United States, 2022" and the manufacturer's label for specific tapering instructions.[38] [39]
- When tapering opioids, closely monitor the patient for signs and symptoms of opioid withdrawal, such as restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, myalgia, mydriasis, irritability, anxiety, insomnia, backache, joint pain, weakness, abdominal cramps, anorexia, nausea, vomiting, diarrhea, increased blood pressure or heart rate, and increased respiratory rate. *Such signs and symptoms may indicate a need to taper more slowly.* Also monitor for suicidal thoughts, use of other substances, or changes in mood.[38]
- If the patient has dementia or another cognitive impairment, don't assume an inability to understand a pain scale or to communicate pain. Experiment with several pain scales to find one that works. A scale featuring faces, such as the Wong-Baker FACES Pain Rating Scale, is a good choice for many cognitively impaired patients and for those with limited language skills. (See *Visual pain rating scale.*)

VISUAL PAIN RATING SCALE

Patients with language difficulties can indicate pain using many instruments. One such instrument is the Wong-Baker FACES Pain Rating Scale (shown below), which uses six faces to help the patient describe the level of pain. Each face corresponds to a number on a 0-to-10 scale. Explain to the patient what each face means before having the patient rate the pain.

To use the FACES scale, explain to the patient that each face represents a person who feels happy because of having no pain or is sad because of having some or a lot of pain. Face 0 is very happy because nothing hurts. Face 2 hurts just a little bit. Face 4 hurts a little more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how the patient is feeling.



Patient Teaching

Teach the patient and family (if applicable) about pain management strategies during discharge planning. Include information about the patient's pain management plan and adverse effects of pain management treatment. Discuss activities of daily living and items in the home environment that might exacerbate pain or reduce the effectiveness of the pain management plan, and include strategies to address these issues. Teach the patient and family about safe use, storage, and disposal of opioids, if prescribed.[4]

Complications

Complications associated with pain management may include:

- untreated or undertreated pain
  - multisystemic effects (such as pallor, elevated blood pressure, dilated pupils, skeletal muscle tension, dyspnea, tachycardia, and diaphoresis)

    - chronic, disabling pain
        - altered functioning
        - decreased quality of life
        - decreased well-being[3]
- accelerated death (from limited mobility, increased physiologic stress, and increased risk of such complications as pneumonia and thromboembolism)[2]
- adverse effects of opioids or other medications for pain treatment
    - respiratory depression (the most serious)
    - drowsiness or sedation
    - constipation
    - nausea
    - vomiting
    - dependence[40]
- substance use disorder.[39]

Documentation

Documentation associated with pain management includes:

- subjective information elicited using the patient's own words
- location, quality, and duration of the pain
    - precipitating factors
- pain management interventions selected
    - response to those interventions
    - pain rating before and after interventions
- medications administered
    - medication name
    - medication strength
    - dose
    - route of administration
    - date and time of administration
    - access site used (if applicable)
    - administration device used
    - rate of administration (if applicable)
- complications of drug therapy
- additional treatments ordered and revisions to the treatment plan if pain wasn't relieved
    - response to those treatments
- teaching provided to the patient and family (if applicable)
    - understanding of that teaching
    - follow-up teaching needed.

This procedure has been reviewed by the Academy of Medical-Surgical Nurses.

AMSN Academy of Medical-Surgical Nurses

Related Procedures

- Pain and comfort management, PACU
- Pain management, home care
- Pain management, nonpharmacologic, neonatal
- Pain management, oncology
- Pain management, pharmacologic, neonatal
- Pain management, physical therapy

Related UpToDate Patient Teaching Handouts

- Chronic pain
- Enhanced recovery after surgery
- How to Keep Track of Your Pain
- Managing acute pain at home
- Managing pain after surgery
- Managing pain during labor and childbirth
- Managing pain in the hospital
- Muscle, joint, and bone pain – Discharge instructions
- Pre-surgery shower
- Taking opioids safely – ED discharge instructions
- What to expect the day of your surgery or procedure

References

(Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions)

1. Hinkle, J. L., & Cheever, K. H. (2021). *Brunner & Suddarth's textbook of medical-surgical nursing* (15th ed.). Wolters Kluwer.
2. Herr, K., et al. (2019). Pain assessment in the patient unable to self-report: Clinical practice recommendations in support of the ASPMN 2019 position statement. *Pain Management Nursing, 20*(5), 404–417. Retrieved April 2025 from https://doi.org/10.1016/j.pmn.2019.07.005
3. American Association of Critical-Care Nurses (AACN). (2018). *AACN practice alert: Assessing pain in critically ill adults*. Retrieved April 2025 from https://www.aacn.org/clinical-resources/practice-alerts/assessing-pain-in-critically-ill-adults (Level VII)
4. The Joint Commission. (2025). Standard PC.01.02.07. *Comprehensive accreditation manual for hospitals.* (Level VII)
5. American Society of PeriAnesthesia Nurses (ASPAN). (2003). ASPAN pain and comfort clinical guideline©. *Journal of PeriAnesthesia Nursing, 18*(4), 232–236. Retrieved April 2025 from https://doi.org/10.1016/S1089-9472(03)00129-1 (Level VII)
6. American Cancer Society. (2024). *Non-medical ways to manage pain*. Retrieved April 2025 from https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/pain/non-medical-treatments-for-cancer-pain.html
7. The Joint Commission. (2025). Standard NPSG.07.01.01. *Comprehensive accreditation manual for hospitals.* (Level VII)
8. Centers for Disease Control and Prevention. (2002). Guideline for hand hygiene in health-care settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *MMWR Recommendations and Reports, 51*(RR-16), 1–45. Retrieved April 2025 from https://www.cdc.gov/mmwr/pdf/rr/rr5116.pdf (Level VII)
9. World Health Organization (WHO). (2009). *WHO guidelines on hand hygiene in health care: First global patient safety challenge, clean care is safer care*. Retrieved April 2025 from https://apps.who.int/iris/bitstream/handle/10665/44102/9789241597906_eng.pdf?sequence=1 (Level VII)
10. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Infection control. 42 C.F.R. § 482.42.
11. Accreditation Commission for Health Care. (2023). Standard 07.02.05. *Healthcare Facilities Accreditation Program: Accreditation requirements for acute care hospitals.* (Level VII)
12. DNV GL-Healthcare USA, Inc. (2024). IC.1.SR.3f. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 24.* (Level VII)
13. The Joint Commission. (2025). Standard NPSG.01.01.01. *Comprehensive accreditation manual for hospitals*. (Level VII)

14. The Joint Commission. (2025). Standard RI.01.01.01. *Comprehensive accreditation manual for hospitals.* (Level VII)
15. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Patient's rights. 42. C.F.R. § 482.13(c)(1).
16. Accreditation Commission for Health Care. (2023). Standard 15.01.07. *Healthcare Facilities Accreditation Program: Accreditation requirements for acute care hospitals.* (Level VII)
17. DNV GL-Healthcare USA, Inc. (2024). PR.2.SR.5. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 24.* (Level VII)
18. Narayan, M. C. (2010). Culture's effects on pain assessment and management. *American Journal of Nursing, 110*(4), 38–47. Retrieved April 2025 from https://doi.org/10.1097/01.NAJ.0000370157.33223.6d
Abstract | Complete Reference
19. The Joint Commission. (2025). Standard PC.02.01.21. *Comprehensive accreditation manual for hospitals.* (Level VII)
20. Waters, T. R., et al. (2009). *Safe patient handling training for schools of nursing.* Retrieved April 2025 from https://www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf (Level VII)
21. The Joint Commission. (2018). *Quick safety 44: Non-pharmacologic and non-opioid solutions for pain management*. Retrieved April 2025 from https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-44-nonpharmacologic-and-nonopioid-solutions-for-pain-management/
22. Lee, J. H. (2016). The effects of music on pain: A meta-analysis. *Journal of Music Therapy, 53*(4), 430–477. Retrieved April 2025 from https://doi.org/10.1093/jmt/thw012 (Level I)
Abstract | Complete Reference
23. Anekar, A. A., et al. (2023). WHO analgesic ladder. *StatPearls*. Retrieved April 2025 from https://www.ncbi.nlm.nih.gov/books/NBK554435/
24. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Nursing services. 42 C.F.R. § 482.23(c).
25. Accreditation Commission for Health Care. (2023). Standard 16.01.03. *Healthcare Facilities Accreditation Program: Accreditation requirements for acute care hospitals.* (Level VII)
26. The Joint Commission. (2025). Standard MM.06.01.01. *Comprehensive accreditation manual for hospitals.* (Level VII)
27. DNV GL-Healthcare USA, Inc. (2024). MM.1.SR.3. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 24.* (Level VII)
28. Centers for Medicare and Medicaid Services. (2014). *Requirements for hospital medication administration, particularly intravenous (IV) medications and post-operative care of patients receiving IV opioids*. Retrieved April 2025 from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-15.pdf
29. Porras, H., & Lammers, C. (2022). *Patient safety events involving opioid dose stacking.* Retrieved April 2025 from https://psnet.ahrq.gov/web-mm/patient-safety-events-involving-opioid-dose-stacking
30. Ganz, D. A., et al. (2013). Preventing falls in hospitals: A toolkit for improving quality of care (AHRQ Publication No. 13-0015-EF). Agency for Healthcare Research and Quality. Retrieved April 2025 from https://www.ahrq.gov/sites/default/files/publications/files/fallpxtoolkit.pdf (Level VII)
31. The Joint Commission. (2025). Standard RC.01.03.01. *Comprehensive accreditation manual for hospitals.* (Level VII)
32. Centers for Medicare and Medicaid Services. (2024). Condition of participation: Medical record services. 42 C.F.R. § 482.24(b).

33. Accreditation Commission for Health Care. (2023). Standard 10.00.03. *Healthcare Facilities Accreditation Program: Accreditation requirements for acute care hospitals.* (Level VII)
34. DNV GL-Healthcare USA, Inc. (2024). MR.2.SR.1. *NIAHO® accreditation requirements, interpretive guidelines and surveyor guidance – revision 24.* (Level VII)
35. Harmon, J. R., et al. (2012). Efficacy of the use of evidence-based algorithmic guidelines in the acute care setting for pain assessment and management in older people: A critical review of the literature. *International Journal of Older People Nursing, 7*(2), 127–140. Retrieved April 2025 from https://doi.org/10.1111/j.1748-3743.2010.00261.x (Level V)
Abstract | Complete Reference
36. Cavalieri, T. A. (2007). Managing pain in geriatric patients. *Journal of Osteopathic Medicine, 107*(Suppl. 4), E10–E16. Retrieved April 2025 from https://www.degruyter.com/document/doi/10.7556/jaoa.2007.20014/html
37. Galicia-Castillo, M. C., & Weiner, D. K. (2024). Treatment of chronic non-cancer pain in older adults. In: *UpToDate*, Schmader, K. E., & Fishman, S. (Eds.).
UpToDate Full Text
38. U. S. Food and Drug Administration (FDA). (2019). *Drug safety communications: FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering*. Retrieved April 2025 from https://www.fda.gov/media/122935/download
39. Centers for Disease Control and Prevention (CDC). (2022). CDC clinical practice guideline for prescribing opioids for pain—United States, 2022. *MMWR Recommendations and Reports, 71*(RR-3), 1–95. Retrieved April 2025 from https://doi.org/10.15585/mmwr.rr7103a1 (Level VII)
40. U.S. National Library of Medicine. (2024). *Opioids and opioid use disorder (OUD)*. Retrieved April 2025 from https://medlineplus.gov/opioidmisuseandaddiction.html

Additional References

- American Society of Anesthesiologists. (2012). Practice guidelines for acute pain management in the perioperative setting: An updated report by the American Society of Anesthesiologists Task Force on Acute Pain Management. *Anesthesiology, 116*(2), 248–273. Retrieved April 2025 from https://doi.org/10.1097/ALN.0b013e31823c1030 (Level VII)
Abstract | Complete Reference | Full Text
- Durham, C. O., et al. (2015). Pain management in patients with rheumatoid arthritis. *Nurse Practitioner, 40*(5), 38–45. Retrieved April 2025 from https://doi.org/10.1097/01.NPR.0000463784.36883.23
Abstract | Complete Reference
- National Center for Complementary and Integrative Health. (2021). *Complementary, alternative, or integrative health: What's in a name?* Retrieved April 2025 from https://www.nccih.nih.gov/health/complementary-alternative-or-integrative-health-whats-in-a-name
- Turner, H. N., & Czarnecki, M. L. (2025). *Core curriculum for pain management nursing* (4th ed.). Elsevier.

Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions

The following leveling system is adapted from *Evidence-Based practice in nursing & healthcare: A guide to best practice,* Fifth edition, by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt (2023).

Level I	Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs)
Level II	Evidence from well-designed single RCTs (experimental)

Level III	Evidence from well-designed nonrandomized controlled trials (quasi-experimental), systematic reviews of a complete body of evidence, and intervention studies using mixed methods
Level IV	Evidence from well-designed case-control and cohort studies (observational)
Level V	Evidence from systematic reviews of qualitative and descriptive studies
Level VI	Evidence from single descriptive and qualitative studies, evidence-based practice implementation, and quality improvement projects
Level VII	Evidence from expert opinion, expert committee reports, and literature reviews

Data from Gyatt, G., & Rennie D. (2002). Users' guides to the medical literature. American Medical Association; Harris, R. P., et al. (2001). Current methods of the U.S. Preventative Services Task Force: A review of the process. American Journal of Preventative Medicine, 20, 21-35.