Pain and opioids

Assessment, pain scales, comfort measures, opioids, naloxone and non-opioids

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1 AT A GLANCE

Believe the client's pain report, assess fully, reassess after every intervention. Opioids are among the most dangerous drugs nurses give.

Acute or chronic

	Acute	Chronic
★ **Timing**	Short-term, with a clear cause	Persists or recurs for **over 3 months**, or beyond expected healing
Vital signs	Often raises pulse, breathing and BP	Usually doesn't change them
Also		Tense muscles, low energy, poor appetite, depression, anger, fear of getting hurt again

Believe the client: Normal vital signs don't mean there's no pain. Neuropathic pain, from nerve damage, often feels like burning, or pins and needles.

Match the scale to the client

Client	Scale
Alert adult	Numeric 0 to 10: 0 is no pain, 10 the worst imaginable
Child generally 3 or older, or can't use numbers	**Wong-Baker FACES**, if they understand the instructions. Pointing alone isn't enough
Infant or young child, or can't report pain	**FLACC**: face, legs, activity, cry, consolability; each 0 to 2, total 0 to 10
★ **Advanced dementia**	**PAINAD**: breathing, vocal sounds, facial expression, body language, consolability

Screen, then assess: A 0 to 10 rating is a screen, not a full assessment: follow it with PQRSTU.

Opioids

	Key points
★ **Morphine dose**	Moderate to severe pain. **No fixed ceiling**, but sedation, respiratory depression and individual response limit the dose. Higher doses may not bring more relief; opioid-induced hyperalgesia can worsen pain. Lowest effective dose; escalate to the prescriber
★ **Breathing**	**First 24 to 72 hours**, and after a dose increase. Highest risk: older or frail, COPD, low oxygen, airway problems
Other sedatives	With benzodiazepines, alcohol or other sedating drugs: profound sedation, coma and death
Other effects	Low BP, dizziness, sedation, nausea, sweating, constipation: track bowel function
Also	Can hide the signs of a head injury (pupils, consciousness); not given with a bowel obstruction. Can trigger seizures, biliary spasm. Reduced doses: enlarged prostate, severe kidney or liver disease, underactive thyroid

PCA and fentanyl patches

	Key points
PCA	**Only the client presses**: a sleepy client who can't press it is a built-in safety check
★ **PCA lockout**	Limits dose frequency, but overdose is still possible: basal infusions, programming or concentration errors, other sedatives. Keep monitoring breathing and sedation
Fentanyl patch	Only for opioid-tolerant clients with severe, ongoing pain; never for new, short-term pain. Worn up to 72 hours
Patch safety	**No heat** on or near it (heating pad, fever): can release a fatal dose. Check every new medicine. Falls off? Fold it sticky sides together. Flush it at home; in a facility, waste it per policy. Apply a new one elsewhere

Naloxone

- Reverses opioid sedation and respiratory depression. IV usually works within 2 minutes; IM starts a little slower but lasts longer.
- ★ **It can wear off before the opioid**: sleepiness and slow breathing can return, and repeat doses are often needed. Keep watching.
- Opioid-dependent client: sudden withdrawal within minutes (aches, sweating, yawning, shivering, restlessness, fast pulse). It usually eases within about 2 hours.

Non-opioids and adjuvants

Drug	Key points
★ **Acetaminophen**	Pain and fever, not inflammation. Over **4,000 mg a day** in adults can cause severe liver damage; lower limits for older adults and heavy drinkers. Count every source, combination pills too. Antidote: acetylcysteine
NSAIDs (ibuprofen)	Pain, fever, inflammation. Boxed warnings: heart attack, stroke; serious stomach bleeding, especially after a past ulcer or bleed
Ketorolac	Limited to 5 days in adults. Not with advanced kidney disease, dehydration, or for pain after heart bypass surgery
Aspirin	Stomach bleeding, ringing ears, severe allergy. Reye's syndrome in children or teens with or after flu or chickenpox
Adjuvants	Gabapentin, amitriptyline: nerve pain; first gabapentin dose at bedtime. Taper baclofen. Cyclobenzaprine: drowsiness, dry mouth, urinary retention

Educational use only. Not a substitute for clinical judgment, your facility's policy or the provider's orders. Where practice varies, follow facility policy and state law. No patient information.

Pain and opioids

1 AT A GLANCE, CONTINUED

Assess with PQRSTU

- **P**: what provokes or relieves it. **Q**: quality, like aching, stabbing or burning.
- **R**: region, and whether it spreads. **S**: severity, often 0 to 10.
- **T**: timing, and treatment tried so far. **U**: understanding: what does the client think is causing it?
- Use open questions and clarify mismatches: "tolerable" but rates it 7? Ask more.

Comfort without medication

- Use alone or with medication; choose with the client. Distraction, relaxation, music, a calm environment, repositioning, TENS.
- Massage 3 to 5 minutes, never over red or swollen areas.
- ★ Heat or cold: thin towel between the pack and the skin. **Never heat over a medication patch**; for implants, follow device guidance. Client can't tell you? Check the skin every 5 minutes.

One textbook range: Heat 5 to 20 minutes, cold no longer than 20. Timing depends on the device, skin integrity, sensation, perfusion and care plan.

2 PRIORITY AND SAFETY CALLS

Assess pain with a scale before and after every dose, and ask what level the client finds acceptable.

Vomiting? An oral dose may not work: choose the best route.

Drowsy with slow breathing after naloxone: stimulate, support breathing, prepare to repeat naloxone per orders, keep monitoring.

Family pressing the PCA button: explain that only the client presses it; sleepiness is a safety check.

Teach: no driving, no alcohol or other sedating drugs. Crushing, chewing, snorting or injecting an opioid can cause a fatal overdose.

Reassess every intervention once it should have taken effect: pain, function and side effects. Document the response.

Evaluate every analgesic: reassess pain and function, and watch breathing, blood pressure and the bowels.

Assistive personnel report pain they notice, and can be delegated repositioning, heat or cold.

4 SELF-QUIZ

1. Chronic pain persists or recurs for over _____ months.
2. For advanced dementia, use the _____ scale.
3. Each FLACC item scores 0 to _____.
4. Opioid respiratory depression is most likely in the first 24 to _____ hours.
5. Given IV, naloxone usually works within _____ minutes.
6. The antidote for an acetaminophen overdose is _____.

ANSWER KEY 1. 3 · 2. PAINAD · 3. 2 · 4. 72 · 5. 2 · 6. acetylcysteine

3 EXAM ANCHORS

1. Normal vital signs don't rule out pain: believe the client.
2. Advanced dementia: PAINAD, not a number scale.
3. No heat over a medication patch; with a fentanyl patch, heat can release a fatal dose.
4. Naloxone can wear off before the opioid: don't leave after one dose.
5. Fentanyl patches are for opioid-tolerant clients, not new pain.
6. Add up acetaminophen from every product over 24 hours, combination pills included.
7. Ketorolac is limited to 5 days in adults.

5 SOURCES

1. Open RN, Nursing Pharmacology 2e, 10.7 Opioid Analgesics and Antagonists. wtcs.pressbooks.pub/pharmacology/chapter/10-7-opioid-an…
2. Open RN, Nursing Fundamentals 2e, 11.3 Pain Assessment Methods. wtcs.pressbooks.pub/nursingfundamentals/chapter/11-3-pa…
3. Open RN, Nursing Fundamentals 2e, 11.4 Pain Management. wtcs.pressbooks.pub/nursingfundamentals/chapter/11-4-pa…
4. Open RN, Nursing Pharmacology 2e, 10.6 Non-Opioid Analgesics. wtcs.pressbooks.pub/pharmacology/chapter/10-6-non-opioi…
5. IASP, Preventing Pain: An Introduction (fact sheet). iasp-pain.org/resources/fact-sheets/preventing-pa…
6. Wong-Baker FACES Foundation. wongbakerfaces.org
7. DailyMed, Fentanyl Transdermal System label. dailymed.nlm.nih.gov/dailymed/drugInfo.cfm
8. DailyMed, Naloxone Hydrochloride Injection label. dailymed.nlm.nih.gov/dailymed/drugInfo.cfm

Built from RN PocketPal course lessons: Pain assessment and nonpharmacological comfort (c03-l07); Pain management and reversal agents (c05-l15). Every line on this sheet comes from those lesson scripts.

COMFORT AND PAIN

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