



Pain Protocol Revised

To clarify requirements for initial and ongoing pain assessments, the following revisions affecting the medical staff have been made:

For inpatient:

- An initial history and physical related to pain is required if the patient's pain rating is > 3 (numerical scale) or > 1 (FACES scale) **or** if the patient indicates that s/he wants pain addressed during the admission.
- An ongoing pain re-assessment shall be performed as part of daily rounds, if pain is > 3 (Numerical) or > 1 (FACES) **or** if the patient indicates that s/he wants pain addressed during the admission.
- If patient experiences new, unrelieved or worsening pain, re-assess for changes from the initial assessment and document in the medical record.
- The Initial Assessment must be documented in the medical record and will include the following elements:
 - Pain intensity (current pain score)
 - For persistent (chronic) pain, obtain pain score reflective of pain on an average typical day.
 - Location
 - Quality
 - Onset, duration, variation, and patterns
 - Alleviating and aggravating factors
 - Present pain management regimen and effectiveness
 - Physical exam/observation of the pain site.
 - Pain management history when persistent pain is present, including medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain
 - Effects of persistent pain, including impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration.

For outpatient:

- Complete the provider section of the Patient Pain Screening Tool for Ambulatory Services.

Refer to the ICPM, PAT025 – Pain, Assessment and Management Protocol for additional details. See Appendix I for the Ambulatory Patient Pain Screening Tool.

Meperidine (Demerol) and Hopkins

There have been problems with the use of meperidine at Johns Hopkins, including a recent sentinel event. Because of its toxicity and efficacy profiles compared to other narcotic analgesics, the Pharmacy and Therapeutics Committee removed the oral formulation from the formulary and restricted the use of parenteral meperidine to the following indications:

- Intraoperative and periprocedure use by anesthesiologists
- Treatment of drug or blood product-induced rigors
- Post-anesthesia shivering
- Documented anaphylactoid reactions to morphine and hydromorphone

Meperidine's active metabolite, normeperidine, is responsible for the majority of side effects. Normeperidine has half the analgesic potency of the parent compound, but two to three times the potency as a CNS excitatory agent. Normeperidine's elimination half-life has been reported to be from 14 – 48 hours. Adverse effects include tremors, myoclonus and seizures. Risk factors for seizures include larger or more frequent dosing, renal insufficiency, chronic use longer than 6 days, and patients with a history of seizures. Naloxone does not reverse the effects of normeperidine and may precipitate seizures in patients receiving meperidine by blocking its depressant action. Several pain management guidelines have

discontinued the use of meperidine for both acute and chronic pain. Some of these include the AHCPR Guidelines for Acute Pain Management (1992), AHCPR Guidelines for Cancer Pain Management (1994), and the American Pain Society's Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (fifth edition 2003). Safer alternatives should be utilized such as morphine, hydromorphone, fentanyl and oxycodone.

Please Note: The total daily dose of meperidine should NOT exceed 600 mg.

*Published under the direction of the Johns Hopkins Hospital Pharmacy and Therapeutics Committee.
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Patient Requests to Amend Medical Records

When a patient requests an amendment to their "final" medical record, it is not a simple matter of responding "yes" or "no" to the patient. Both HIPAA and state law come into play. When a patient requests such an amendment, the patient must complete and sign HIPAA form A.6.3.a, Request To Amend My Protected Health Information. The form is available on the Johns Hopkins HIPAA Intranet site (www.insidehopkinsmedicine.org/hipaa under the Forms/Policies for Providers link on the left hand side of the home page).

The completed request must be forwarded to the Johns Hopkins HIPAA Privacy Officer by whomever receives it at Johns Hopkins. There are certain standards and procedures required by HIPAA as well as certain time lines that must be met. The HIPAA Office keeps extensive records on this process in the event of a complaint. Keep in mind that Maryland law does not allow health care providers to remove documentation from the patient's medical record once finalized (signed). The HIPAA Privacy Regulations require us to have a licensed health care provider review the amendment request and determine whether an amendment is appropriately made. The Johns Hopkins Privacy Officer works with Dr. Rosenstein to have these requests reviewed.

Dictation of Medical Records

It is vital that clinic notes, operative reports, and discharge summaries be dictated with patient records in front of you and not from memory.

2005 Risk Management Seminars

Risk Management Seminars will be held during the following dates and times in Hurd Hall. Contact your departmental credentials coordinator if you are unsure whether you need to attend.

- 5/18/05 5:30-6:30
- 7/12/05 5:30-6:30
- 9/13/05 5:30-6:30
- 10/15/05 11-noon
- 11/16/05 5:30-6:30
- 12/13/05 5:30-6:30

A list of Risk Management Seminars can also be found at http://www.insidehopkinsmedicine.org/news/attachments/risk_management_2005.cfm

JHH Medical Staff News
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410-955-0620