



**NON-HOSPITAL MEDICAL AND SURGICAL FACILITIES  
ACCREDITATION PROGRAM**

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College of Physicians and Surgeons of British Columbia

# **Pain Infusion Clinic**

## **STANDARD**

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Approved: January 2014

Revised: June 19, 2019

Originating committee: Non-Hospital Medical and Surgical Facilities Accreditation Program  
Committee

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## Preamble

This document is intended for non-hospital medical/surgical facilities that provide complex pain management services to ensure that best practices are incorporated into facility policies and procedures. Complex pain management services provided in the non-hospital setting must be acceptable to and approved by the College of Physicians and Surgeons of BC. Complex pain management services in the non-hospital setting are currently limited to include only ketamine and lidocaine infusions.

## College's Position

The College recognizes the need for access to pain medicine and that high-quality pain care requires documentation with reliable measurements of outcomes. The College also recognizes that effective pain management is dependent on a coordinated, interdisciplinary approach that is based upon accurate assessment of pain and a comprehensive approach to pain management that includes both non-pharmacological and pharmacological methods for treatment.

The purpose of these standards is to allow qualified physicians and other qualified, regulated health-care professionals to administer ketamine and lidocaine infusions for the treatment of complex pain in the non-hospital medical/surgical facility setting in patients where conventional pharmacological and non-pharmacological methods for pain have been unsuccessful and to provide these patients with the benefits of multidisciplinary pain care while minimizing the associated risks.

The College's guidance of non-hospital facilities is to ensure the safety, quality, and consistency of patient care and is not meant to replace the professional judgment of physicians and other health-care professionals but rather incorporate current evidence-based or consensus-based clinical information into a framework for reasonable and acceptable patient care that promotes the best possible patient outcomes.

The decision to recommend ketamine and/or lidocaine infusions for pain treatment requires multidisciplinary input to evaluate the indications for treatment and to define and determine the most effective pharmacological and non-pharmacological strategies, management interventions, and current and future primary treatment plans. Facilities must assure commitment, organization, leadership, personnel and physical sources to provide optimal care.

Physicians, other regulated health-care professionals, and support personnel must demonstrate the requisite training, skills, and experience to administer a comprehensive pain program. The College relies primarily upon certification processes from the Royal College of Physicians and Surgeons of Canada (RCPSC) in order to determine which physicians can be designated as specialists in a given field of practice. Presently the RCPSC is working toward approving accredited residency programs in pain medicine. In the meantime, pain specialists practising before July 2016 will require evidence of additional training in pain medicine acceptable to the College of Physicians and Surgeons of BC.

Non-hospital surgical facilities approved to provide ketamine and lidocaine infusions are required to have a designated in-patient hospital to which patients can be transferred if the need arises. These facilities must be located within a 10-minute drive of a hospital in case of emergency transfer.

## Definitions Pertaining to All College Guidelines

<b>mandatory:</b>	Required by authority; obligatory, compulsory. A compulsory descriptor identified in NHMSFAP standards. Unfulfilled mandatory descriptors will result in immediate requirements with specified time frames for follow-up.
<b>recommendation:</b>	Expression of an action which is advisory in nature.
<b>requirement:</b>	Expression of an action which is essential or mandatory.
<b>shall or must:</b>	Indicates mandatory requirement and best practice, i.e. the minimum standard.

## Definitions for Pain Infusion Clinics

### Abbreviations

<b>ACLS:</b>	advanced cardiac life support
<b>BLS:</b>	basic life support (CPR level health professional)
<b>BMI:</b>	body mass index (weight in kilograms divided by the square of the height in metres)
<b>ASA:</b>	American Society of Anesthesiology – patient’s anesthesia physical status classifications according to risk
<b>CAS:</b>	Canadian Anesthesiologists’ Society
<b>CRNBC:</b>	College of Registered Nurses of BC
<b>CSA:</b>	Canadian Standards Association
<b>NHMSFs:</b>	non-hospital medical/surgical facilities
<b>OSA:</b>	obstructive sleep apnea
<b>PCA:</b>	patient controlled analgesia
<b>RN:</b>	registered nurse

### Glossary of terms

<b>adult:</b>	Persons 19 years of age or older. Confirms the rights of adults to make their own health-care decision, either independently or with support from family and friends. Adults can be given health care only with their consent ( <i>BC’s Adult Guardianship Laws: Supporting self-determination for adults in British Columbia</i> ).
<b>Aldrete scale:</b>	Clinical scale used as criteria for patient discharge from PACU. The Aldrete scale scores the patient on mobility, respiratory status, circulation, consciousness, and pulse oximetry.

<b>anesthesiologist:</b>	All licensed medical practitioners with privileges to administer anesthetics. The only route to specialist recognition in anesthesia in Canada is through the RCPSC's certification process. Physicians may be required to provide anesthesia services. CAS guidelines are intended to apply to all anesthesiologists in Canada. In the NHMSF setting only RCPSC-certified anesthesiologists may provide anesthesia services.
<b>antagonist:</b>	A drug that competes with agonists for opioid receptor binding sites; can displace agonists, thereby inhibiting their action (e.g. naloxone).
<b>appropriateness:</b>	The degree to which service is consistent with requirements and current best practice.
<b>benzodiazepines:</b>	Any of a group of psychotropic agents used as anti-anxiety agents, muscle relaxants, sedatives and hypnotics (e.g. midazolam, diazepam, lorazepam). Co-administration of benzodiazepines may be indicated for the prevention and treatment of the dissociative effects of ketamine.
<b>best practice:</b>	An approach that has been shown to produce superior results, selected by a systematic process, and judged as exemplary, or demonstrated as successful. A best practice is a technique or methodology that, through experience, research and expert opinion has proven to reliably lead to a desired result.
<b>college:</b>	Professional regulatory body.
<b>committee:</b>	Non-Hospital Medical and Surgical Facilities Accreditation Program Committee.
<b>comorbidity:</b>	Two or more coexisting medical conditions or disease processes that are additional to an initial diagnosis.
<b>competence:</b>	Guarantee that an individual's training, knowledge and skill are appropriate to the service provided and assurance that the training, knowledge and skill levels are regularly evaluated.
<b>consent:</b>	Refer to BC's <i>Health Care (Consent) and Care Facility (Admission) Act</i> : <a href="http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181_01">http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181_01</a>
<b>guideline(s):</b>	An instructional guide or reference to indicate a course of action or appropriate options. They incorporate the most current evidence-based or consensus-based clinical information into a framework that promotes the best patient outcomes. They do not define a standard of care, but may inform the standard of care. They are not intended to replace the professional judgment of physicians.
<b>high-alert medications:</b>	Medications that bear a heightened risk of causing significant patient harm when used in error as defined by the Institute for Safe Medication Practices (ISMP) (e.g. ketamine).

<b>independent double-check:</b>	The process where two regulated health-care professionals separately check (alone and apart from each other, then compare results) each component of prescribing, dispensing and verifying the high-alert medication for errors before it is administered to the patient. The health-care professional checking has to form an independent judgement without clues from the health-care professional doing the initial work.
<b>ketamine:</b>	A dissociative anesthetic agent capable of producing amnesia, analgesia and all degrees of sedation, including general anesthesia. Low-dose ketamine is sometimes used to treat neuropathic pain or other painful conditions in patients where standard conventional pain therapies have been unsuccessful. There are no antagonists to ketamine. Naloxone reverses the analgesia associated with ketamine but does not reverse the dissociation.
<b>lidocaine:</b>	A local anesthetic and antiarrhythmic drug. Lidocaine is sometimes used to treat neuropathic pain or other painful conditions in patients where standard conventional pain therapies have been unsuccessful.
<b>practitioner:</b>	An individual who practises a learned profession and supplies health-care services (e.g. physician, RN).
<b>policy:</b>	A principle or guideline that governs activities in a facility that employees are expected to follow.
<b>protocol:</b>	Description of the steps to be taken in a procedure. Formal ideas, written plans and expectations concerning the actions of those involved in patient care.
<b>qualified:</b>	Having the education, abilities, qualities, training, or certification to perform a particular job or duties.
<b>reversal agents:</b>	Agents that act by interfering with the benzodiazepine or narcotic's action (e.g. flumazenil for benzodiazepines and Naloxone for narcotics).
<b>regulated health-care professional:</b>	Applies to a health-care professional who is licensed and in good standing with their regulatory college.
<b>sedation:</b>	A state of reduced excitement or anxiety that is induced by the administration of a sedative agent.
<b>standard:</b>	That which is established by authority as a model, criterion, or rule and serves as a basis for comparison. Authoritative statements that describe the responsibilities for which individuals are accountable. Reflect the values and priorities of the profession. An achievable level of performance against which actual performance is compared.

## Pain Infusion Clinic Standard

### ***I. Medical director and facility requirements***

The medical director must make application in writing to the College for approval to administer a pain infusion program. Approval is contingent on the completion of an on-site visit and confirmation of the following requirements:

1. Meet physical space and design requirements as determined by the Canadian Standards Association (CSA Z8000) and the American Institute of Architects (Design Guidelines)
2. Review patient outcome data to confirm patient safety and satisfactory long-term patient outcomes:
  - a. monthly for the first six months of a new pain infusion program and frequently thereafter
  - b. as part of the physician's annual reapplication for privileges
3. Ensure the physicians working in the facility and facility itself continue to meet all requirements at time of annual reappointment for privileges, including review of the patient outcome data (documentation of continuing medical education related to pain medicine is recommended)
4. Provide key staffing and/or referral requirements:
  - a. one qualified pain physician (anesthesiologist) who is designated as director of the pain infusion program and who can provide documentation that:
    - they practise pain medicine in the context of an inter-professional pain management program that includes physicians, nurses, psychologists, pharmacists, social workers, occupational therapists and physiotherapists as needed
    - the most responsible physician is clearly established
    - appropriate follow-up care services are established to ensure longitudinal coordinated care for a patient
  - b. critical care or post-anesthesia recovery nursing staff who are qualified and experienced in advanced pain management
  - c. an anesthesiologist must remain on-site until all patients have met established criteria for discharge
    - two regulated health professionals—one anesthesiologist plus one RN, or two anesthesiologists—must remain on-site until all patients have met established criteria for discharge
  - d. administrative support staff

## **II. Practitioners' qualifications**

### **All pain medicine physicians must:**

- be an anesthesiologist certified by the RCPSC and be licensed and in good standing with the College of Physicians and Surgeons of BC

**Note:** Other non-anesthesiologist physicians with training and experience in pain medicine acceptable to the College will be considered in the future.

- hold privileges in a facility approved by the College
- possess requisite experience in managing complex pain, including:
  - completion of postgraduate training in pain medicine and experience which is acceptable to the College (completion of RCPSC certification in pain medicine will be required in the future)
- hold privileges in pain infusion procedures approved by the College
- hold active hospital privileges in the practice of anesthesia, **or** hold current ACLS training and have completed an airway management course if they have not practised anesthesia in a hospital setting within three years
- have privileges and coverage available 24/7/365 at a designated in-patient hospital to manage pain medicine complications

### **Qualified and regulated health-care professionals (e.g. RN) must:**

- be licensed and be in good standing with their professional regulatory authority (e.g. College of Registered Nurses of BC)
- possess critical care or post-anesthesia certification and/or have the equivalent in training and experience in providing critical care or post-anesthesia care
- possess training and experience in the care and management of patients with complex pain
- hold current ACLS training

## **III. Staffing requirements**

**In all areas of patient care delivery, the facility must ensure sufficient personnel are available to assist with patient transferring and/or ambulation as necessary.**

During the pain infusion, the following staffing requirements must be met:

1. Two critical care/post-anesthesia RNs, or one anesthesiologist and one critical care/post-anesthesia RN must be present in the same room at all times where a patient is receiving a pain infusion
2. The following staffing ratios **must** be met:
  - a. One RN to one patient
    - at the time of initiation of the pain infusion, until the following critical elements are met:
      - three q5 min VS and sedation score (15 minutes) and three q15 min VS and sedation score (45 minutes) are complete

- sedation score is less than 3
  - patient is hemodynamically stable
  - initial assessment is complete
  - patient is hemodynamically unstable, e.g. blood pressure drop of 15 mmHg or increase of 30 mmHg (systolic or diastolic) or change in pulse rate of 20/min
  - respiratory rate less than 6/min
  - sedation score is equal to 3
  - a second nurse must be available to assist as necessary
- b. One RN to two patients:
- first hour of infusion is complete
  - both patients have a sedation score of less than 3
  - both patients are hemodynamically stable
3. An anesthesiologist must remain on-site until all patients have met established criteria for discharge

#### ***IV. Practice guidelines***

##### **a. Medical records**

A permanent record of all pain procedures will be maintained and must include at a minimum:

- name and address of patient
- names of physicians and other health-care professionals directly involved in patient care
- medical history and physical exam including height and weight
- record of allergies and medications
- comprehensive pain assessment (see appendix B)
- pain management plan (see appendix B)
- informed consent (see appendix A)
- consultations as indicated
- 12 lead ECG
- laboratory and/or diagnostic testing as indicated by the patient's medical status, drug therapy or nature of the pain management (e.g. serum lidocaine levels)
- nursing record including patient status on discharge
- standardized pain assessment tool
- medication administration record

##### **b. Patient selection and screening**

Inappropriate patients for a NHMSFAP pain infusion clinic:

- ASA > 3
- BMI  $\geq$  45
- patients with no responsible escort to drive them home
- untreated severe OSA and/or patients who are non-compliant with CPAP
- significant cardiac comorbidity (e.g. recent MI, CHF, significant valve disease, ischemic heart disease, significant arrhythmia)
- significant pulmonary comorbidity (e.g. severe COPD/emphysema, severe restrictive lung disease, poorly controlled asthma)
- significant renal or liver disease
- significant confounding psychiatric and/or psychosocial factors, e.g. suspected somatoform pain disorder, recent or current substance/alcohol abuse issues
- contraindications to ketamine use (e.g. severe arterial hypertension, hyperthyroidism, CNS space occupying lesions, glaucoma)
- contraindications to lidocaine use (e.g. uncontrolled seizures, bradycardia, second- or third-degree heart block, hypovolemia)

Appropriate patients for a NHMSFAP pain infusion clinic must meet **all** of the following criteria:

- patients aged 19 years or older
- patients with persistent, life-altering pain (e.g. average daily pain intensity  $\geq$  6/10 over a period of a least six months)
- standard conventional pharmacological and complementary pain therapy (e.g. physical therapy, massage therapy) have been unsuccessful

### **c. Patient admission**

The regulated health-care professionals managing the patient care must:

- confirm and document that the patient has a responsible adult to accompany them home
- review the patient chart for completeness (e.g. consent, history and physical, allergies, medications, 12 lead ECG, etc.)
- confirm the identity of the patient and confirm patient consent to the proposed care and treatment (see appendix A)
- obtain and document baseline data including heart rate and rhythm, respiratory rate and status, blood pressure, pulse oximetry, sedation level, pain assessment including location and intensity, weight, allergies, glucometer as indicated
- provide patient with the appropriate information regarding the treatment, nature of medications and post-treatment care

**d. Pain infusion unit/area**

The regulated health-care professionals managing the patient care must ensure the following:

- there is an adequate number of patient stations equipped with dedicated monitoring equipment, which includes:
  - ECG monitor
  - suction
  - oxygen source with mask and/or nasal cannula
  - bag-valve-mask device
  - intravenous supplies
  - medications and narcotics
  - emergency light source
- adequate space exists to allow for free movement of staff and emergency equipment access on both sides of the patient stretcher
- an appropriately qualified and trained RN is present in the same room at all times where a patient is receiving a pain infusion
- an anesthesiologist must remain on-site until all patients have met established criteria for discharge

**e. Patient care and monitoring**

**Ketamine IV infusion**

The regulated health-care professionals managing the patient care must ensure the following:

- IV access must be established for all patients
- ketamine infusion dosing is restricted to a weight-based infusion dose limit of 2 mg/kg/hr and a total dose of 1000 mg/day including initial loading dose, re-boluses and infusion
- ketamine infusions are prepared **only** by a pharmacy
  - commercially packaged or pharmacy-prepared pre-mixed solutions of ketamine will be used
  - whenever possible a single standard concentration should be used
- ketamine infusions are administered via a dedicated line
- ketamine infusions are administered **only** via an infusion control device/syringe pump with a locked control panel
- an independent double-check of the following must be completed prior to initiating the infusion which includes:
  - medication order including patient name, medication, dose and route
  - medication strength/concentration
  - dosing formula (e.g. mcg/kg/min, units/hr)

- weight, if applicable
- pump settings
- documentation of independent double-checks
- loading doses and re-boluses are administered **only** by an anesthesiologist
- administration is by continuous infusion only, i.e. not by PCA or bolus dosing
- ongoing patient assessment and documentation is completed:
  - three q5 min, then three q15 min for the first hour
  - q1 hour for the next three hours
  - q4 hour until infusion completed
  - 30 minutes after the infusion is discontinued
- ongoing patient assessment and documentation is completed more frequently as indicated (e.g. unstable patient, medication dosage, dose increase, etc.)
- ongoing patient assessment and documentation includes:
  - respiration rate
  - heart rate and rhythm
  - blood pressure
  - sedation level
  - pain scale
  - oxygen saturation by pulse oximetry as indicated (e.g. sedation score > 2, sleep apnea, spot oximetry less than 94%)
  - infusion pump settings (e.g. dose and rate)
- the patient remains in the pain infusion area for a minimum of 30 minutes after the pain infusion is discontinued
  - IV access must be maintained until discharge criteria is met

### **Lidocaine IV or SC infusion**

The regulated health-care professionals managing the patient care must ensure the following:

- IV access must be established for all patients
- lidocaine infusions are prepared **only** by a pharmacy
  - commercially packaged or pharmacy-prepared pre-mixed solutions of lidocaine will be used
  - whenever possible a single standard concentration should be used
- infusions are administered via a dedicated line
- lidocaine infusions are administered **only** via an infusion control device/syringe pump with a locked control panel

- an independent double-check of the following must be completed prior to initiating the infusion which includes:
  - medication order including patient name, medication, dose and route
  - medication strength/concentration
  - dosing formula (e.g. mcg/kg/min, units/hr)
  - weight, if applicable
  - pump settings
  - documentation of independent double-checks
- loading doses are administered only by an anesthesiologist
- administration is by continuous infusion only, i.e. not by PCA or bolus dosing
- ongoing patient assessment and documentation is completed:
  - three q5 min, then three q15 min for the first hour
  - q1 hour until infusion completed
  - 30 minutes after the infusion is discontinued
- ongoing patient assessment and documentation is completed more frequently as indicated (e.g. unstable patient, medication dosage, dose increase, etc.)
- ongoing patient assessment and documentation includes:
  - respiration rate
  - heart rate and rhythm
  - blood pressure
  - sedation level
  - pain scale
  - oxygen saturation by pulse oximetry as indicated (e.g. sedation score > 2, sleep apnea, spot oximetry less than 94%)
  - infusion pump settings (e.g. dose and rate)
- the patient must remain in the pain infusion area for a minimum of 30 minutes after the pain infusion is discontinued
  - IV access must be maintained until discharge criteria is met

**f. Patient discharge**

- Discharge criteria must be met prior to discharge of the patient from the facility
- The patient and/or guardian/responsible adult will be instructed in the after-care of the patient; verbal and written discharge instructions will be given to the patient and/or responsible adult and must include:
  - when to resume taking medications taken before the pain infusion
  - instructions to not take additional sedative medications or alcohol

- instructions for no driving, operating dangerous machinery or strenuous activity for the rest of the day
- follow-up care, telephone contact numbers for the anesthesiologist
- written materials applicable to the pain infusion
- An anesthesiologist must remain on the premises until the patient meets predetermined discharge criteria—discharge from the facility is the responsibility of the anesthesiologist

**g. Equipment**

- Lighting is adequate for the safe delivery of patient care
- Emergency power and lighting is available and routinely tested
- Adequate electrical outlets are available
- Medical gas piping system complies with CSA standards and is serviced semi-annually in accordance with CAN/CSA Z73396-1-12 and/or medical gases are provided by cylinders located at the bedside
- All equipment is CSA approved and checked annually by a biomedical engineer

**h. Infusion/syringe pumps**

- Make/model of pumps are limited within the facility
- Pumps are equipped with a free-flow protection mechanism
- All health-care staff including physicians receive comprehensive training on the use of pumps
- Pump use instructions are clear and readily available
- A failure mode and effects analysis (FEMA) is conducted when acquiring new pumps and annually for pumps currently in use

**i. Emergency management**

- The facility must have appropriately trained personnel and the appropriate equipment to deal with emergencies that relate to the airway, cardiac function and to the management of complications of the pain infusion
- The emergency cart must be stocked in accordance with the NHMSFAP Emergency Cart Medication and Equipment standard for a class 1 facility
- The emergency cart is immediately available
- Protocols for the contact of EMS and patient transfer to a hospital must be published, posted and regularly reviewed

**j. Medication management**

- Controlled drugs and substances (e.g. narcotics) must be managed in a manner that permits full auditing of the substances from acquisition through to patient administration and wastage

**k. Safety**

- All equipment and supplies must be appropriate, CSA approved and calibrated according to the manufacturer’s recommended standards
- All equipment must undergo annual inspection and maintenance by qualified personnel, (i.e. biomedical engineer)—records indicating conformity to regulations and inspection and maintenance must be retained by the facility
- Emergency mock drills must be performed at least every six months which should include, but are not limited to, cardiac arrest, difficult airway management, anaphylaxis, hypovolemia, unresponsiveness, acute stroke and seizure—all staff must participate in mock drills with attendance and specified drills practised documented

**l. Physical space**

- There must be adequate space in the facility for the health-care team to deliver safe, private and efficient patient care in all patient areas
- The facility must be easily accessible by emergency medical services and fire department

**m. Infection prevention and control management**

- “Routine practices” shall be employed in the handling of all patients, care items and medical devices
- Sufficient handwashing sinks shall be available and handwashing protocol posted as a visible reminder of the importance for staff to wash their hands
- Appropriate personal protective devices shall be employed by all staff
- Aseptic and/or sterile technique shall apply as appropriate to procedure(s) performed
- All sharps devices must be handled appropriately and disposed of in a dedicated biohazard puncture resistant container—see WorkSafeBC regulation at [www.worksafebc.com](http://www.worksafebc.com) – Reference OSHR 6.36(1)
- Single-use medical devices (e.g. syringes) must not be reused
- Ensure that potentially infectious materials or agents are not transferred from one patient to another; special attention shall be given to syringes, infusion pump administration sets and multi-dose medication vials

**n. Sterile processing management**

Facilities are required to verify the following:

- the Ministry of Health’s *Best Practice Guidelines for the Cleaning, Disinfection and Sterilization of Critical and Semi-critical Medical Devices in BC Health Authorities* (December 2011) is incorporated into facility policy and followed:  
<http://www.health.gov.bc.ca/library/publications/year/2011/Best-practice-guidelines-cleaning.pdf>

**o. Quality improvement program**

Non-hospital facilities approved to perform pain infusions must have a quality improvement program in place to monitor the quality of pain management across the continuum of care. Long-term pain management follow-up must be established for all patients.

The quality improvement program must include documentation of the use of best practices and measuring outcomes. Suggested outcome data includes, but is not limited to, quality of life, improvement in symptoms or functional status, and patient satisfaction.

Documentation of the quality improvement program is reviewed during the application process for establishing a pain program and at time of accreditation.

**p. Manuals**

- Policies and procedures pertaining to pain infusions, including clinical pathways/care algorithms, shall be current, complete and available for staff to review
- Education materials relevant to the services provided at the facility

## Appendix A

### **Consent**

A “rolling” consent is suitable for the same treatment performed consecutively. Confirmation that the consent remains valid must be documented at each patient visit.

As per the Ministry of Health’s *Health Care Providers’ Guide to Consent in Health Care* (July 2011), the patient may be asked to consent to a number of similar procedures that are part of an overall course of health care, including repetitions of certain procedures. In this situation, the physician should get consent for the full course of treatment at the outset. The health care can then continue until there is a change in the course of treatment or until the adult refuses the health care.

If there is a change to the care plan, or a new procedure/treatment not covered by the previous consent is introduced, consent for the new treatment must be obtained.

The health-care provider delivering health care is responsible for ensuring, to the extent possible, that the consent remains valid throughout the ongoing delivery of care.

Consent provided for a course of health care is valid unless:

- the adult withdraws consent at any time
- in the period between the giving of consent and the commencement of treatment, there is a change in the adult’s condition and the treatment consented to may no longer be medically appropriate
- the health-care provider’s knowledge about the condition changes in a way that affects either the original information given to the adult, or the plan for subsequent procedures

For further information, refer to the Ministry of Health’s *Health Care Providers’ Guide to Consent in Health Care*.

## Appendix B

### ***Pain assessment and pain management plan***

A comprehensive pain assessment must be documented for all patients. This assessment should also include consultations by other members of the interdisciplinary pain management team.

The comprehensive pain assessment must include:

- detailed medical history
- pain assessment including factors that relate to pain tolerance
- physical exam
- relevant laboratory and other diagnostic tests
- medication history including over the counter drugs, alternative and complementary therapies
- complementary pain therapies (e.g. physical therapy, massage therapy)
- psychosocial assessment (e.g. anxiety, depression, coping responses to stress and pain)
- effects on activities of daily living

The pain assessment must include:

- intensity of pain at its worst, at rest and on movement
- extent of pain relief achieved (response)
- barriers to implementing the treatment plan
- effects of pain on ADLs, sleep and mood
- side effects of medications for pain
- level of sedation
- strategies used to relieve pain, e.g. analgesic doses taken regularly and for breakthrough pain, non-pharmacological interventions

Pain reassessments must be performed regularly and documented.

A plan for pain management must be documented and should take into consideration the following factors:

- assessment findings
- baseline characteristics of pain
- physical, psychological, and sociocultural factors shaping the experience of pain
- etiology
- most effective pharmacological and non-pharmacological strategies
- management interventions
- current and future primary treatment plans

## Appendix C

### *Sedation scale*

Level 0	None
Level 1	Mild, occasionally drowsy, easy to wake
Level 2	Moderate, frequently drowsy but easily awaken
Level 3	Severe, difficult to awaken
S	Normal sleep, easy to awake

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### Revision History

Version No.	Version Date	Summary of Changes
3.0	2019-06-19	<ul style="list-style-type: none"> <li>• Updated airway management course requirements</li> <li>• Updated BMI to be congruent with revised Obesity Guideline</li> <li>• Updated IV Ketamine Dosing</li> <li>• New Reference added: Consensus Guidelines on the Use of Intravenous Ketamine Infusions for Chronic Pain</li> </ul>
2.0	2017-12-30	<ul style="list-style-type: none"> <li>• Program name change</li> </ul>