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|  Management of Pain | NO. 689 |
| **Policy**Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our resident the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement.We will achieve these goals through:• Promptly and accurately assessing and diagnosing pain.• Encouraging residents to self-report pain.• Aggressively assessing pain in non-verbal and cognitively impaired residents.• Increasing comfort and reducing depression and anxiety in resident.• Optimizing the residents’ ability to perform activities of daily living.• Monitoring treatment efficacy and side effects.A standard format for assessing, monitoring and documenting pain in both cognitively intact and cognitively impaired residents will be utilized. As part of a comprehensive approach to pain assessment and management, pain will be considered the “fifth” vital sign at the facility, along with temperature, pulse, respiration, and blood pressure. For the purposes of this policy, pain is defined as “whatever the experiencing person says it is, existing whenever the experiencing person says it does”. **Procedure**1. **Resident/Family Involvement**

 Upon admission, all residents and families will receive encouragement to report pain early so pain management can be more effective. Residents and families will be asked to periodically measure  satisfaction related to pain and its management.1. **Physician Communication and Involvement** – Pain will be assessed and managed in a timely fashion,

 especially if it is of recent onset. The physician will be notified of resident’s complaint of pain when not relieved by medication as ordered by the physician. Thorough communication with the physician will ensure an appropriate pain management plan.1. **Nursing Involvement**:
	1. Pain Questionnaire

 Upon admission, readmission, each MDS assessment, change of condition or when pain is suspected, the patient will be assessed for pain.* 1. Comprehensive Pain Assessment
1. The Pain Assessment measures the impact of pain on the resident’s function, assessing the

 resident’s physical condition, history, mental status, and ADLs. The assessment will cover the following areas: intensity, location, onset, type and frequency, description, change, treatment, effect, and what makes it better or worse. |
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| **3. Nursing Involvement, continued..** **B. Comprehensive Pain Assessment** 2. A licensed nurse will complete the Pain Assessment. **C. Pain Reassessment** The licensed nurse will repeat the Pain Assessment under any of the following circumstances: • Resident is on routine pain medication and pain is not controlled, persistent, or worsening. • Pain medication use is significantly increased. • A change in pain related behavior, cognition, or mood occurs. **D. Choose a Pain Rating Scale** During the Pain Assessment, determine the most workable Pain Rating Scale for the resident. When  documenting pain, identify the pain scale used and specify the parameters so the meaning of the pain rating is clear, consistent, and relevant for the resident. The following scales are available: • The numeric rating scale (NRS) • The verbal descriptor pain rating scale (VDS) • Non-verbal pain indicators (NVPI)**4. Nursing Observation**Nursing observation is an important part of the pain assessment, especially in the non-verbal resident. Using the chart provided with the pain assessment, nursing will observe behaviors that may indicate painin the non-verbal or cognitively impaired resident. Pain may be indicated when there are changes in thefollowing: • facial expressions• vocal behaviors• body movements• routines• mental status**5. Physical Examination** The nurse will complete a physical evaluation of the resident that includes the following: vitals, bowel  sounds, lung sounds, and objective observation of the painful area. The physician may complete a more  thorough examination if needed. **6. Drug Review** Drug Therapy will be reviewed on a regular basis by the physician and pharmacist.**7. Side Effects** Staff will monitor for medication side effects and initiate treatment as needed. The most common side effects are constipation, drowsiness and nausea. Physician will order lab work as needed to monitor liver and  kidney function. |
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| **8. Plan of Care** Initiate an interdisciplinary plan of care based on the initial assessment, the choice of a pain rating scale, and the development of pain relieving strategies. Include both pharmacological and complementary  interventions in the care plan. **9. Pain Flow Sheet** Initiate a pain flow sheet for all residents reporting pain regardless of the treatment (pharmacological) and/or non-pharmacological). The effectiveness of pain interventions should be measured 1-2 hours after administration of treatment using the pain scale chosen by the resident or the behavioral indicators.**10. Documentation** Document interventions and responses in the medical record as appropriate (i.e. medication administration record, treatment record, nursing progress notes, etc.) and on the pain flow sheet. Communicate pain protocol and pain levels to the MDS Coordinator to ensure proper pain coding on the MDS.**11. Education** Staff: All facility staff will receive training in pain management during orientation and annually. **12. Quality Improvement** A percentage of residents on Pain Management will be reviewed quarterly as part of the Continuous Quality Improvement program. Facility Pain Quality Measure scores will also be reviewed. |
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