

# Pain Management Program

<b>Purpose</b>	To establish a program that can effectively manage pain in order to remove adverse physiologic and physiologic effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness.
<b>Policy</b>	It is the policy of the facility to facilitate resident independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish the goals through an effective pain management program.
<b>Definition</b>	The resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital sign changes, and changes in behavior and mood will be used to determine the presence of pain.
<b>Components of the Pain Management Program</b>	<ul style="list-style-type: none"><li>• Accurate standardized format for performing assessments</li><li>• Accurate and complete documentation of pain assessment and monitoring</li><li>• Schedule of the frequency of assessments</li><li>• Informed resident participation in care decisions, including managing pain</li><li>• Resident education to self-report pain, and family/sponsor education when appropriate</li><li>• Aggressive assessment of non-verbal residents for signs and symptoms of pain</li><li>• Pain to be considered the 5<sup>th</sup> vital sign, along with temperature, pulse, respiration and blood pressure</li><li>• Annual staff education assessment and pain management</li><li>• Input from all disciplines</li><li>• Pain medication shall be appropriate for the population served</li><li>• Quality Assurance audit activities to monitor the program's effectiveness</li><li>• Medications for the control or relief of anxiety</li></ul>
<b>Standards</b>	<ol style="list-style-type: none"><li>1. Pain assessment protocol may be initiated under any of the following situations:<ul style="list-style-type: none"><li>• Any indication of pain based on the Pain Assessment performed for each resident at the time of admission, quarterly and with any condition change associated with the potential of pain</li><li>• When the MDS triggers an indication of pain (section J2, J3)</li><li>• Resident received routine pain medication and/or pain is not controlled</li><li>• A change in resident condition occurs to require pain control</li><li>• A significant increase in the need for use of PRN use of pain mediation</li><li>• A change in pain identification related to behavior, cognition or mood</li><li>• Resident has a diagnosis of a disease that is associated with pain or discomfort</li></ul></li><li>2. As soon as possible identify the best rating scale for the resident and use the same rating scale to determine the level of pain</li><li>3. An immediate care plan will be initiated at the time of admission for any resident with physician orders for pain management, when the resident expresses pain, or exhibits behaviors indicative of having pain.</li><li>4. All care givers are instructed to report the resident's or family's report of pain or discomfort</li></ol>

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5. An interdisciplinary process and care plan will be developed and implemented based on the assessed findings, pain rating scale, and pain relieving strategies (interventions).
6. Pharmacological and non-pharmacological interventions will be included in the care plan and addressed in direct and indirect care assignments
7. Care plans will be reviewed and updated each time the resident's pain management plan is found not to be effective and at least at each quarterly care conference.
8. Nursing and other staff member assignments include information regarding the resident's plan to control pain.
9. Resident and family/sponsor education included but is not limited to:
  - Types of pain the resident actually or potentially may experience
  - Pain control mechanisms available and/or have been employed
  - Potential limitation of pain management and treatment
  - Potential and/or actual side effects of pain management and treatment
  - Determination of the resident's acceptable level of pain, i.e., the terminally ill resident may wish complete relief from pain, knowing this may render him/her in a semi-somnolent state; or may request relief from pain to the degree where pain may still be experienced, however his/her ability to remain mentally alert and relate to family/significant others remains in tact.
10. Pain management is addressed as a component of the discharge planning process.
11. Documentation of assessments and the resident's response to the pain management plan will be made with each assessment.
12. The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medications.
13. Pain control will be assessed during routine medication passes
14. Around the clock pain management should be considered when the resident has pain 12 out of 24 hours
15. Interventions to be considered to supplement not replace drug therapy to manage pain may include the following:
  - Repositioning
  - Ambulation
  - Mild Exercise
  - Therapeutic massage, back rub
  - Diversion techniques, i.e., television, video or DVD viewing or reading
  - Therapeutic communication
  - Spiritual counseling
  - Visitation from family and significant others
  - Relaxation breathing exercises