Policy on Pain Assessment and Management in Elderly Care

A. PURPOSE:

Effective pain assessment and management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal pain management enhances healing and promotes physical and psychological wellness.

The purpose of this Policy is to provide guidelines to facilitate effective pain management and comprehensive pain control in order to provide patient comfort and optimal functioning as well as patient and family satisfaction.

B. DEFINITIONS:

Pain - is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is whatever the individual experiencing it says it is, existing whenever the individual says it exists.

Pain Assessment - Pain assessment is considered as the 5th vital sign. It is the assessment of pain that is performed when pain is reported.

Comprehensive Pain Assessment - Is the assessment process that includes evaluation of the origin/cause, location, duration, intensity, aggravating and alleviation factors, effects of pain, and the current pain regime effectiveness, that is performed if the initial pain screening indicates a history of persistent or current pain.

Pain Management - Refers to management of general pain other than chest pain and includes invasive, non-invasive, non-pharmacological and pharmacological interventions

Pain Intensity Level - The pain rating reported by the patient that signifies the presence and intensity of pain, using the Pain Scale.

Unrelieved pain – A pain score that remains above the identified pain goal for an extended period of time.

Acute pain – a transient pain that subsides as healing takes place and has a predictable end; and is normally localized.

Persistent pain - pain that persists for longer than three months beyond the usual course of an acute disease or healing time. Pain that is associated with a persistent pathological process that causes continuous or recurrent pain.

Pain Scale -A tool to assess pain intensity and tolerance

C. Principles:

- The patient has the right to appropriate assessment and management of pain.
- Unrelieved pain has consequences and should be prevented as far as possible and must requires urgent treatment
- Pain is a subjective, multidimensional and variable experience, and requires a critical analysis of pain-related factors and interventions.

D. Implementation:

1. Comprehensive Pain Assessment will be performed if the initial Pain Screening reveals a history of persistent or current pain.
2. Perform Pain Assessment if the ongoing pain screening indicates pain or as soon as the patient reports any pain.
3. Administer scheduled medications at prescribed intervals to achieve and facilitate comfort.
4. Collaborate with the doctor to prevent or treat any adverse reactions or side effects of the medication.
5. PRN pain medication may be administered to facilitate effective pain management for patients with constant pain or in anticipation of painful activities/procedures as prescribed by the doctor.
6. Reassess the patient within 60 minutes after pain medication has been administered, to evaluate the effectiveness of pain management interventions and to recognize any undesirable side effects or adverse reactions.
7. Develop an individualized pain management plan in collaboration with the patient/family and members of the interdisciplinary team.
8. Provide patient / family education regarding pain management. Education should include:
    a. Risks associated with use of analgesics.
    b. Pain Assessment Scales.
    c. Pain Management prescriptions and non-pharmacologic options.
    d. Acceptable pain intensity goal.
    e. Importance of the need to communicate and report pain, so that assessment may be performed and interventions can be implemented.
    f. Individualized Pain Management Plan including management of constipation and other side effects.
9. Sedation assessment will be performed after the administration of opioids to identify the patient's level of alertness.
10. Document all assessments, side effects, adverse reactions, and effectiveness of the pain management plan, as well as all health education and communication to the patient/family in the relevant documentation.

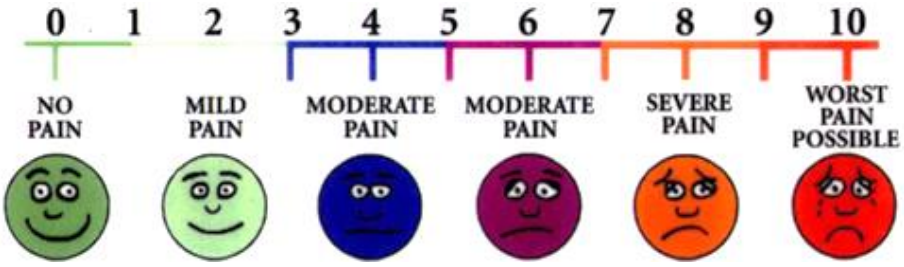
E. The Components of Pain:

- Origin/Cause/Onset of pain
- Location of pain
- Duration of pain
- Time pattern
- Pain intensity/quality
- Radiation Characteristics
- Aggravating factors
- Alleviating factors
- Effects of pain on the patient and family
- Is the current pain regime effective?

F. The Pain Assessment Tool

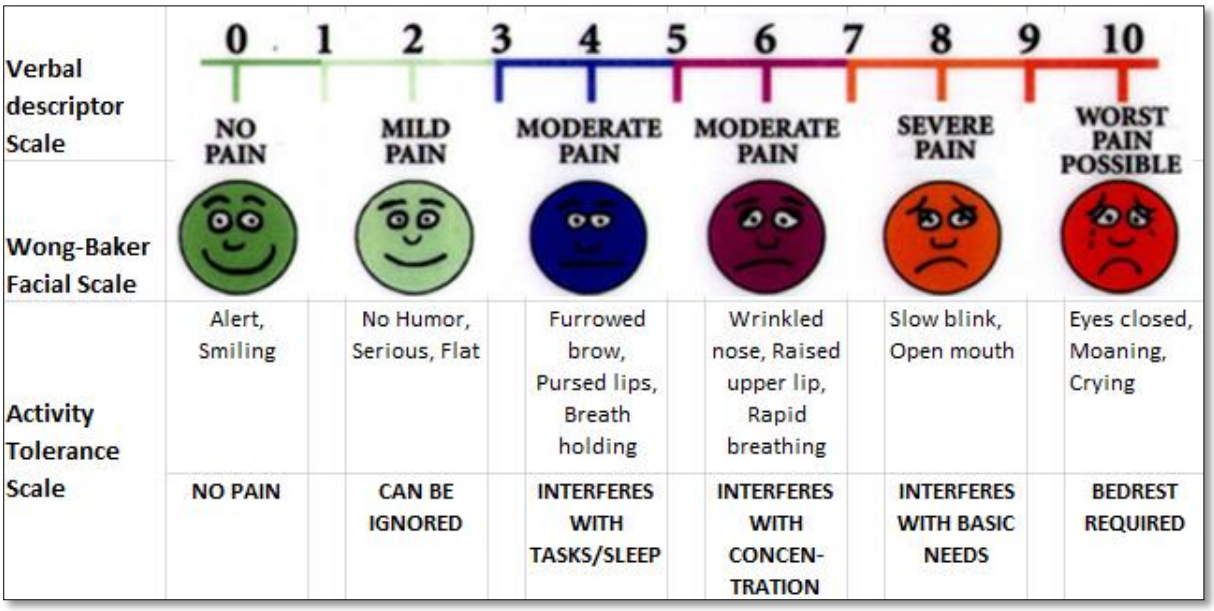
a) **The Wong-Baker Faces Pain Rating Scale** will be used in collaboration to the pain scale to assist the patient and the nurse in choosing the correct pain rating. This tool must be used for residents with severe Dementia or Communication Difficulties.

b) **The 0-10 Numeric Pain Scale** will be used to assess pain in all patients who can identify and communicate (verbally or non-verbally) their level of pain. When measuring the intensity of the symptoms, use the ratings 0-10, where 0 indicates no pain and 10 indicates the worst possible pain.



The Universal Pain Assessment Tool

This pain assessment tool is intended to help the patient and care providers to assess pain according to individual patient needs.
Explain and use the 0-10 Scale for the patient self-assessment.
Use the faces or behavioural observations to interpret expressed pain when a patient has difficulty to, or cannot communicate his/her intensity of pain.



Instructions to use the Universal Pain Assessment Tool:

1. The patient is asked the following question:

On a scale of 1-10, what number (or face) would you give your pain right now? Where 0 is no pain and 10 is the worst possible pain that you can have.

2. Numeric Rating Scale in the following manner:
    a. 0 = No Pain
    b. 1-3 = Mild Pain (nagging, annoying, interfering little with ADLs)
    c. 4–6 = Moderate Pain (interferes significantly with ADLs)
    d. 7-10 = Severe Pain (disabling; unable to perform ADLs)
3. Intervention:
    a. Report and Record pain scale immediately to the RN in charge
    b. Analgesics should be given when the pain scale is 3 or above.
4. Re-assessment must be done within 60min if the patient had any pain, and appropriate actions must be taken to prevent, reduce or relief pain.

G. Resources:

- The International Association for the Study of Pain
- wongbakerfaces.org
- www.webcitation.org/6Ag75MDIq