

Pain Management Policy

Purpose: To provide adequate analgesia for our residents. This is a mutual determined goal between resident an/or family and health care professionals.

Principles of pain management:

1. Develop and reinforce a facility-wide expectation that pain can and will be relieved.
2. Every resident will have a pain assessment done on admission. Residents offering only vague answers must be assessed objectively by the nurse. It will be kept on The chart under the care plan section.
3. Each resident with pain will have a nursing diagnosis on their Careplan addressing the issue. This problem will be reviewed quarterly by the care plan team. This ensures that pain management will be charted on at least quarterly.
4. A pain scale will be used to assess level of pain.
A numerical scale will be used for coherent communicative residents.
Scale being 0-10
0=baseline or no pain 1= mild pain up to 10= excruciating pain

The wong-baker faces will be used to aid nurses in assessing level of pain in moderately impaired residents.

The observation scale used in non-coherent or non-communicative residents.
(See copy of scales attached)

The scales will be kept in the front of the MARS and on the medication cart.

5. Residents receiving PRN pain medications are to be assessed with these Pain scales. It will be recorded on the MARS PRN record.
6. Residents receiving scheduled pain meds will be assessed according to nursing Interventions on the care plan and addressed in the care plan notes on a quarterly basis during Care Plan review.
7. Pain management policy will be a part of orientation for all contact nursing staff.
8. All medications for pain will be ordered by a physician.
On admission orders for pain medication will be reviewed for appropriateness. Physician will be informed if pain is present without admission orders for pain Medications.
9. Effectiveness of pain medications will be monitored by nursing staff.