**Weston Assisted Living**

**Pain Management Policy and Procedure**

**Policy:** Pain Assessment

All residents have the right to accurate assessment, monitoring and management of pain. An assessment will be initiated for all residents identified as experiencing pain in an effort to identify the location, intensity, quality and characteristics of the pain in the residents own words, if possible. Pain management will be initiated for all residents experiencing pain, in order to ensure comfort to the highest level and also in order to achieve the highest practicable level of physical, mental and psychological functioning.

**Purpose:** To ensure that all residents receive adequate and appropriate pain management.

**Procedure / Responsibility / Action:**

1. The most accurate and reliable evidence of the existence of pain and its intensity is the resident’s report. If the pain screening conducted as part of the initial nursing admission assessment indicates that the resident is experiencing pain, a registered nurse will utilize the Pain Assessment Tool to evaluate the resident for pain and to aid in the development of a pain management plan.

2. Residents will also be evaluated for the presence of pain at any time during their stay, including at a minimum, upon admission, during monthly wellness checks, on the day of discharge, and when warranted, if they have any of the following diagnoses: metastatic disease, arthritis, pressure ulcers, and end stage disease with documented diagnosis and deteriorating clinical course or any other medical condition which causes pain. Findings in response to these evaluations will be documented in the resident’s medical records.

3. In addition, residents who have recently undergone surgery, those who are receiving rehabilitation services, or those who express pain or appear to be in pain will also be evaluated for the presence of pain.

4. The assessment will focus on identifying the cause of the pain as well as developing an effective pain management plan. Pain management is most successful when the underlying cause of pain is identified and treated definitively. If the resident is unable to describe the pain or otherwise provide information in this regard, or is cognitively impaired, the Wellness Nurse will seek information from the resident’s family/other representative.

5. In response to the objective/subjective symptoms of pain identified in response to the completion of the Pain Assessment Tool, the registered nurse will work with the resident, Health Service, and the physician, as necessary, to formulate an immediate plan to manage the resident’s pain.
6. When the pain management has been devised and implemented, the 72 hour Pain Monitoring Form will be initiated to document the methods of pain management and to record their effectiveness in managing the resident’s pain.

7. When the information on the 72 hour Monitoring Form indicates that the pain management plan is ineffective, the nurses’ primary goal will be the promotion of comfort of the resident. The physician and/or the interdisciplinary team will be advised of the ineffectiveness of current interventions and another pain management plan will be devised and implemented.

The Physician will:

- Assess resident and may write orders for pain management. Provide documentation of the findings and treatment plan. (Note that the selection of drug, dosage, and frequency must be based on the individual resident’s needs.
- Order pain management consult indicated. Consultation specialists may include neurologists, oncologists, psychiatrists, and Hospice staff.

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