

PAIN: A SYSTEMATIC APPROACH

A systematic approach to management of pain includes involvement of an interdisciplinary team **including** the physician.

Screening – Initial and routine for residents:

- Complete Minimum Data Set (MDS):
 - Upon admission
 - Quarterly
 - With change in condition
- Ask questions such as:
 - Are you in pain now?
 - Does it hurt anywhere?
 - How is your pain today compared to yesterday/your worst day?
 - Does your pain keep you from sleeping at night?
 - Does your pain keep you from participating in activities?
 - Do you have pain every day?

Comprehensive assessment – If pain is identified upon screening:

- Description of pain, intensity, location, frequency, pain at least/worst, aggravating/alleviating factors, current treatment, response to current treatment
- Utilize a standardized pain scale:
 - Visual analogue scale
 - Verbal numeric scale with visual thermometer
 - Face numeric scale
 - PAINAD (Pain IN Advanced Dementia) tool on non-communicative residents

Determine the underlying cause of pain and address it via a care plan – If medication use is appropriate, consider the following:

- If activity exacerbates pain, medicate **before** activities including:
 - Therapy
 - Bathing
 - Wound care
 - Turning
 - Recreational activities
- If pain medication is utilized **more** than occasionally, consider **scheduled dosages**
- Medications may be more effective when used with complementary treatments including:
 - Exercise
 - Massage
 - PT/OT positioning
 - Meditation
 - Aromatherapy

“Fifth Vital Sign” – Conduct regular assessments and incorporate into practice standards

Monitoring treatment effectiveness

- Monitor for pain at least on a daily basis
- Pain scales: minimally daily, with med changes, changes in condition
- Designate responsibility for monitoring
- Record monitoring results in the medical record



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