## Purpose

# To provide optimal pain control, assessment and monitoring guidelines for pain management

# To assess every resident for pain

# To treat all residents experiencing for pain

# To prevent complications related to acute and chronic pain

# **Definition**

Pain is whatever the resident says it is.

# **Procedure**

1. Every resident will be assessed for pain:
	1. Upon admission and readmission
		1. Every resident will be screened for pain via the Nursing Admission Assessment within eight hours. If the resident is experiencing pain, a comprehensive Pain/Discomfort Assessment will be completed
	2. Quarterly
	3. As needed for new, worsening and unresolved pain
	4. When pain is indicated on the current MDS
2. Nurses will use the following 0-10 pain intensity scale when assessing pain:

PAIN INTENSITY SCALE

**MILD**

MODERATE

SEVERE

HORRIBLE

VERY

SEVERE



**MILD**

MODERATE

SEVERE

HORRIBLE

VERY

SEVERE

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**MILD**

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HORRIBLE

VERY

SEVERE

1. Once pain has been identified, the resident’s responseto pain medication, interventions, and treatment will be tracked and monitored either in the electronic medication administration record.
2. If applicable the family or legal representative will be informed of:
	* 1. Their role in the pain management of the resident
		2. Side effects of pain treatment
		3. The pain management process used
		4. Medication changes
		5. Importance of their feedback to ensure effective pain control