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	Original	YY MM DD 07 10 25

All Care Centres must have processes for screening, assessing and monitoring resident pain in compliance with Alberta Health Standards for Continuing Care Centres. The pain process has been developed using the National Guidelines included in "A Guide to End of Life Care for Seniors" (2000) and the American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). The goal of the pain process is to improve pain assessment and management in the Care Centre setting. Care Centres will be audited on an ad hoc basis.

Screening

- Staff are required to screen residents for pain within 7 days of admission, every three months (quarterly) and/or when pain is verbalized or observed.
- Staff are required to document results of pain screening on Tool A or B

Tool A is used for all residents who are able to answer the questions on the tool. Completion of the MDS assessment requires information on the resident's "Pain Symptoms" (J2- frequency and intensity) and "Pain Site" (J3). Tool A plus a MDS 7 day tracking tool provides information needed to complete J2 and J3.

Tool B is used with residents who are unable to answer the questions on Tool A. (residents with moderate to severe dementia or who are uncommunicative). Completion of the MDS assessment requires information as identified above. Tool B combined with Tool F provides information needed to complete J2 and J3.

Assessing

- If pain was identified upon screening, staff are required to complete a comprehensive pain assessment within 7 days. **Tool C** includes all the components required for this assessment.
- If the resident is unable to answer the questions included in Tool C, staff will use the monitoring information from Tool F in addition to Tool C as part of the pain assessment.
- Based on pain assessment, a resident specific care plan must be documented.

Monitoring

- Pain must be monitored using the appropriate tool.

Tool D must be used for residents who are able to provide the information needed and must continue until the pain goal is achieved.

Tool E and **F** are used for residents who are cognitively impaired or who are unable to provide the needed information. Tool E is completed by the RN/LPN and must continue until the pain goal is achieved. Tool F is completed by the PCA and must continue until the pain goal is achieved.

NOTE:

Care Centres are not required to use the tools identified in this process, however, the information contained in the tools must be documented on the resident record.

calgary health region

PAIN SCREENING, ASSESSING AND MONITORING For Continuing Care Residents

Is the resident able to answer the Pain **SCREENING (Tool A)** questions?
- Admission
- Quarterly
- Pain suspected

YES → RN/LPN/PCA to complete tool and initiate 7-day MDS tracking using 0-10 scale

NO → RN/LPN/PCA to complete Checklist of Nonverbal Pain Indicators **(Tool B)** and initiate Tool F for 7-day MDS tracking

Enter in medical record and/or MDS. Is pain identified?

YES → Complete comprehensive Pain **ASSESSMENT** Tool **(Tool C).** For residents with cognitive impairment or who are uncommunicative, complete relevant sections. Disciplines including MD to provide input

Identify pain diagnosis and add interdisciplinary plan to care plan

MONITOR pain utilizing Flow Sheet for Cognitively Intact residents **(Tool D)**

For cognitively impaired residents, RN/LPN to complete (**Tool E)** and PCA to complete Facial Grimace and Behavior Checklist **(Tool F)**

Continue monitoring until pain goal is achieved

NO → Continue to Screen:
1) Upon admission
2) At each quarterly review
3) Whenever pain is suspected

Alberta Health Services CALGARY ZONE

PAIN SCREENING: Tool A

NOTE: PAIN RATING (when entering into MDS)

0 = NONE
1 - 3 = MILD
4 - 6 = MODERATE
7 - 10 = HORRIBLE or EXCRUCIATING

- May be completed by PCA/LPN/RN.
- Complete on all residents on admission, each quarterly review, and whenever pain is susp
  questions, complete the Checklist for Non-verbal Pain Indicators (Tool B).

Resident Name : _____ Date : *DD*_____*MM*_____*YY*_____

Staff Interviewer: _____

Interviewer: *"I want to ask you some questions about pain."*	**Yes**	**No**	**Don't know**	**No response or non-sense response**	**Refused to answer**	**Pain Location**
1. Do you have pain (ache, hurt, soreness) anywhere right now? *(Specify location)*						
1a. If yes, ask "on a scale of 0 to 10 with 0 meaning no pain and 10 being the worst pain you can imagine, how much pain are you having now? *(Rate 0-10)*						
2. Does pain ever keep you from doing things you enjoy (e.g. social activities – walking, going to the dining room for meals, knitting, bingo, going outside)?						
3. Does pain ever keep you from sleeping at night?						
4. Do you have pain every day? *(Specify location)*						

If the resident responds "YES" to any of the above, report to RN/LPN who will initiate a Comprehensive Pain Assessment (Tool C). For MDS, utilize this information combined with 7-day tracking.

Reported to RN/LPN >> Name: _____ Date: *MM*_____*DD*_____*YY*_____

Alberta Health Services CALGARY ZONE

Note: PAIN RATING (When entering into MDS)
0 = NONE
1 - 3 = MILD
4 - 6 = MODERATE
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PAIN SCREENING: Checklist for Nonverbal Pain

- May be completed by PCA/LPN/RN
- Complete on all residents who are unable to complete Pain Screening Tool A

Resident Name :_____ Date : *DD*_____*MM*_____*YY*_____

Staff Interviewer:_____

Check if behavior is observed.

	With Movement	At Rest	Pain Location
1. Nonverbal expression of pain: moans, groans, grunts, cries, gasps, sighs			
2. Facial grimaces/ winces: furrowed brow, narrowed eyes, tightened lips, jaw drop, clenched teeth, distorted expressions *(Use facial scale rating: 0 - 10)*			
3. Bracing: clutching or holding onto side rails, bed or tray table, or affected areas during movement *(Specify location)*			
4. Restlessness: constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still			
5. Rubbing: massaging affected area *(Specify location)*			
6. Vocal complaints: verbal words expressing discomfort or pain, “ouch”, “that hurts”, cursing during movement, or exclamations of protest: “stop”, “that is enough”			

If the resident is exhibiting any of the above behaviors, report to RN/LPN who will initiate a Comprehensive Pain Assessment (Tool C).
For MDS, utilize this information combined with Facial Grimace & Behavior Checklist (Tool F).

Reported to RN/LPN >> Name: _____ Date : *DD*_____*MM*_____*YY*_____

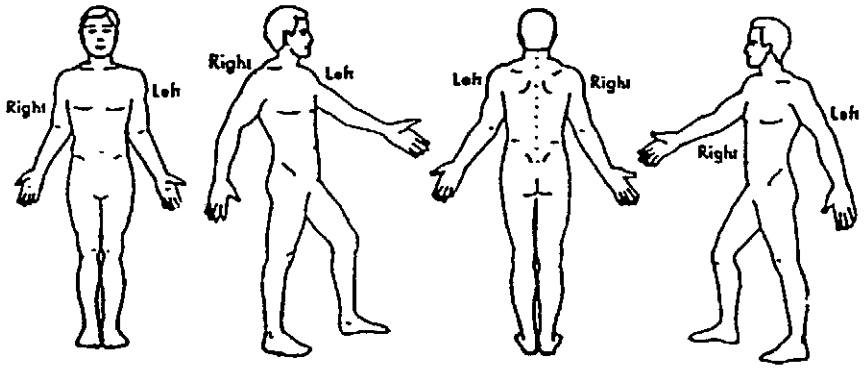
Feldt, K. S. (1996). Treatment of pain in cognitively impaired versus cognitively intact post hip fractured elders. (Doctoral dissertation, University of Minnesota, 1996). Dissertation Abstracts International, 57-09B, 5574
Feldt, K. S. (2000) Checklist of Nonverbal Pain Indicators. Pain Management Nursing, 1 (1), 13-21

Pain Assessment: Tool C

Assessment Date: _____

Name: _____

Location of Pain: Use letters to identify different pains.

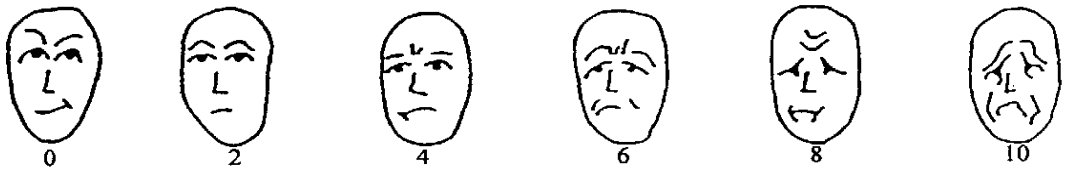


Intensity: Use appropriate pain tool to rate pain subjectively/objectively on a scale of 0-10. *

Location:	***Pain A***	***Pain B***	***Pain C***	***Other***
* What is your/their present level of pain?				
What makes the pain better?				
* What is the rate when the pain is at its least?				
What makes the pain worse?				
* What is the rate when the pain is at its worst?				
Is the pain continuous or intermittent (come & go)?				
When did this pain start?				
What do you think is the cause of this pain?				
* What level of pain are you satisfied with?				

Quality: Check the words that best describe each pain you have. Indicate which area(s) the word(s) describes (Pain A, B, or C)

☐ Aching	_____	☐ Throbbing	_____	☐ Shooting	_____	☐ Stabbing	_____
☐ Gnawing	_____	☐ Sharp	_____	☐ Burning	_____	☐ Tender	_____
☐ Exhausting	_____	☐ Tiring	_____	☐ Penetrating	_____	☐ Numb	_____
☐ Nagging	_____	☐ Hammering	_____	☐ Miserable	_____	☐ Unbearable	_____
☐ Tingling	_____	☐ Stretching	_____	☐ Pulling	_____	☐ Other	_____



no pain mild discomforting distressing horrible excruciating

Adapted with permission from Brignell, A. (2004). Guidelines for developing a pain management program. A resource guide for long term care facilities, 4th edition

Effects of pain on activities of daily living.	yes	no	Comments
sleep and rest			
social activities			
appetite			
physical activity and mobility			
emotions			
Sexuality / intimacy			

Effects of Pain on your Quality of Life: (happiness, contentment, fulfillment)
What can't you do that you would like to do or what activity would improve the resident's quality of life?

_____

_____

Current Medications and Usage:

_____

_____

Family Support: _____

Symptoms:
What other symptoms are you/they experiencing?

constipation ☐ nausea ☐ vomiting ☐ fatigue ☐ insomnia ☐
depression ☐ short of breath ☐ sore mouth ☐ weakness ☐ drowsy ☐
other: _____

Behaviours:
What behaviours are you/they experiencing?

calling out ☐ restless ☐ resistant to movement ☐ not eating ☐ pacing ☐
not sleeping ☐ withdrawn ☐ noisy breathing ☐ rocking ☐ other_____

Have you experienced a significant degree of pain in the past? How did you manage that pain? _____

_____

Is there anything else you can tell us that will enable us to work with you in managing your pain? _____

_____

Nursing Pain Diagnosis:

nociceptive ☐ visceral ☐ neuropathic ☐ suffering ☐ incident pain ☐ somatic ☐
muscle spasm ☐ raised intracranial pressure ☐

Problem List: (add to resident care plan key concerns identified from assessment)

1._____2._____3._____4._____

Signature: _____ Date: _____

Alberta Health Services CALGARY ZONE

Pain Flowsheet for Cognitively Intact
Tool D

- RN/LPN to complete to monitor effectiveness of pain interventions and side effects.

Resident Name _____ **Pain Goal** _____ (identified by resident)

*Pain Rating from 0-10 with 0 being no pain and 10 being worst pain you can imagine.

Date/Time	Location of Pain	Pain Rating Before Treatment*	Pharmacological Interventions	Non-Pharmacological Interventions**	Side Effects ***	Sedation Level ****	Initials	Follow-up Pain Rating*	Initials

*** Non-pharmacy interventions:**
A. Cold
B. Heat
C. Exercise
D. Distractions
E. Massage
F. Music
G. Positioning
H. Physiotherapy
I. Other

*****Side effects:**
A. Constipation
B. Nausea/Vomiting
C. Confusion
D. Hallucinations
E. Itchiness
F. Urinary Retention
G. Respiratory Depression
H. Other

******Sedation level:**
0-Alert
1-Sometimes drowsy
2-Frequently drowsy, easy to arouse
3-Somnolent, difficult to arouse
S-Normal sleep, easy to arouse

Alberta Health Services CALGARY ZONE

Pain Flowsheet for Cognitively Impaired/Uncommunicative
Tool E

no pain **mild** **discomforting** **distressing** **horrible** **excruciating**

- RN/LPN to complete to monitor effectiveness of pain interventions and side effects.

Resident Name _____ **Pain Goal** _____ (facial grimace and/or behavioral indicators)

*Pain Rating from 0-10 using Facial Scale or verbal description

Date/Time	Discomfort Indicators**	Pain Rating Before Treatment*	Pharmacological Interventions	Non-Pharmacological Interventions***	Side Effects ****	Sedation Level *****	Initials	Follow-up Discomfort Indicators	Initials

**** Discomfort Indicator:**
A. Verbal reports
B. Facial grimaces/winces
C. Bracing
D. Restlessness
E. Rubbing
F. Moaning/groaning/crying
G. Other
H. No indicators present
I. Other

***** Non-pharmacy interventions:**
A. Cold
B. Heat
C. Exercise
D. Distractions
E. Massage
F. Music
G. Positioning
H. Physio
I. Other

******Side effects:**
A. Constipation
B. Nausea/Vomiting
C. Confusion
D. Hallucinations
E. Itchiness
F. Urinary Retention
G. Respiratory Depression

*******Sedation level:**
0-Alert
1-Sometimes drowsy
2-Frequently drowsy, easy to arouse
3-Somnolent, difficult to arouse
S-Normal sleep, easy to arouse

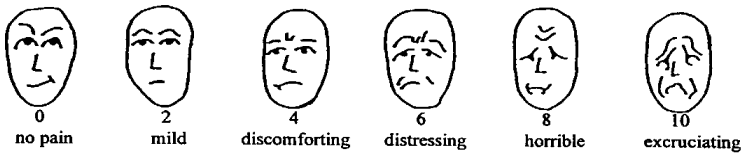
Adapted from Institutionalizing Pain Management Project, University of Wisconsin, Madison.

Alberta Health Services CALGARY ZONE

Facial Grimace & Behaviour Checklist Flow Charts: Tool F

- PCA/LPN/RN to complete at a minimum of once per shift

Name: _____



PAIN RATING (when entering into MDS)
0 = NONE
1 - 3 = MILD
4 - 6 = MODERATE
7 - 10 = HORRIBLE or EXCRUCIATING

Date (yyyy/mm/dd):																				
Shift:	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
Facial Score: 10																					
8																					
6																					
4																					
2																					
0																					

Facial Grimace Score

The facial grimace scale scores the level of pain from 0-10 as assessed by the caregiver observing the facial expressions of the resident. Record the greatest level of pain observed during the shift.

FOR MDS DATA ENTRY, USE THIS INFORMATION AND TOOL B FOR INTENSITY (J2b).

Behaviour Checklist

10 - Always	8 - Mostly	6 - Often	4 - Occasionally	2 - Rarely	0 - Never

Date (yyyy/mm/dd):																				
Shift:	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N
• eats poorly																					
• tense																					
• quiet																					
• indicates pain																					
• calls out																					
• paces																					
• noisy breathing																					
• sleeps poorly																					
• picks																					
• other																					

Behaviour Checklist

Behaviour changes are used to assess pain or distress. The behaviours being rated and scored are listed down the left column. The caregiver can expand on the checklist, i.e., rocking, screams, etc. Complete the checklist based on observations of the resident's behaviour(s) during the shift.

FOR MDS DATA ENTRY, USE THIS INFORMATION FOR FREQUENCY (J2a).

Saint Joseph's Health Centre, Sarnia Ontario, Palliative Care Research Team.
Adapted with permission. Brignell, A. (2004). Guidelines for developing a pain management program. A Resource guide for long-term care facilities, 4th edition.