

Pain Management Program

Policy, Procedures and Training Package

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ABOUT THIS DOCUMENT

The development and implementation of an interdisciplinary program for pain management is a requirement of Regulation 79 of the *Long-Term Care Homes Act, 2007* (LTCHA). This document contains sample program objectives, policy, procedures and staff training materials and tools that meet the minimum requirements of the LTCHA and regulation.

This package is intended to be used as a resource for OANHSS member homes to modify and customize, as appropriate. This material can also be used by homes to review their current policies and procedures and compare content. Please note: The project team have compiled these materials during the fall of 2010, and as a result, the information is based on the guidance available at this time. Members will need to regularly review the Ministry of Health and Long-Term Care (MOHLTC) Quality Inspection Program Mandatory and Triggered Protocols to ensure that internal policies and procedures align to these compliance expectations.

Program Evaluation: As described in the regulation, core clinical programs must be evaluated and updated at least annually by Long Term Care Homes, in accordance with evidence-based practices and if there are none, in accordance with prevailing practices. **Note: a program evaluation approach is not included in this document.** However, OANHSS is planning to develop resource materials on the topic of integrative program evaluation approaches for its members in the near future.

Acknowledgements

OANHSS gratefully acknowledges the contribution of written practices, resources and tools used in the development of this package from Belmont House, Grey Bruce Palliative Care/Hospice Association, Huron Lodge -The Corporation of The City of Windsor, Ukrainian Canadian Care Centre, Welland Hospital Extended Care.

PAIN MANAGEMENT PROGRAM

Purpose

The purpose of the Pain Management Program is to maintain an interdisciplinary team approach to pain management that provides the resident with optimal comfort, dignity and quality of life.

The program focuses on:

- communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired
- strategies to manage pain including non-pharmacologic interventions, equipment, supplies, devices and assistive aids, and comfort care measures
- monitoring of residents' responses to and the effectiveness of the pain management strategies.

The program ensures team training, communication and effective care planning.

Objectives

- To improve and maintain a resident's optimal functional level and quality of life.
- To optimally control pain for all residents.
- To reduce incidence of unmanaged pain.
- To ensure best practice interventions for residents with pain.
- To monitor and track trends related to pain management.

Policy

Each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes. Residents experiencing pain must be treated using non-pharmacological and pharmacological methods to optimally control pain, maximize function and promote quality of life.

RAI-MDS 2.0 assessment protocols and outputs will be reviewed in relation to pain and pain control with each new full assessment.

Definition

Pain: An unpleasant subjective experience that can be communicated to others through self-report when possible and/or a set of pain-related behaviors; it is an unpleasant sensory and

emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Types of pain:

- Acute pain - is relatively brief, and subsides as healing takes place.
- Chronic pain - continues for a long period of time, generally is not curable, and can have episodes of exacerbation whereby certain activities or other conditions may cause the pain to reoccur.
- Neuropathic pain - stimuli abnormally processed by the nervous system.

RAI-MDS 2.0 Definition: Pain that is reported is unrelieved pain. If the resident does not have any pain due to pain management, then it is coded as “0” for no pain.

Note: The following are barriers that can interfere with pain assessment and treatment in the elderly:

- Under reporting of pain
- Choosing to suffer in silence
- Perception of pain by others
- Cognitive functioning
- Fear of losing self-control
- Fear of addiction
- Inability to swallow pills.

Research has demonstrated there is a strong relationship between pain and symptoms of depression, therefore the Depression Rating Scale (DRS) may also be reviewed in the presence of pain.

Procedure

The following section outlines the interdisciplinary team approach to roles and activities for pain management. Roles and functions assigned may vary across homes due to availability of these resources. These steps are samples that homes may use as a guide for their specific program procedures.

Pain Assessment & Management

Registered Nursing Staff:

1. Screen resident at least once a day during routine assessments by asking the resident/Substitute Decision Maker (SDM) about the presence of pain, ache or discomfort. A pain scale can be used as needed to determine pain intensity (Appendix A: Pain Scales).
2. Collaborate with resident/SDM, family and interdisciplinary team to conduct the pain assessment utilizing a clinically appropriate instrument (Appendix B: Pain Assessment Tool).

- within 24 hours of admission
- quarterly (according to the RAI-MDS 2.0 schedule)
- when a resident exhibits a change in health status or pain is not relieved by initial interventions.

For example, the resident:

- states he/she has pain
 - is diagnosed with chronic painful disease
 - has history of chronic unexpressed pain
 - is taking pain-related medication for >72 hours
 - has distress related behaviours (e.g. changes in anxiety level) or facial grimace
 - indicates that pain is present through family/staff/volunteer observation.
3. Assess psychological and behavioural indicators in the non-verbal, cognitively impaired person such as:
 - flat affect
 - decreased interaction
 - decreased intake
 - altered sleep pattern
 - rocking
 - negative vocalization
 - frown or grimacing
 - noisy breathing.
 4. In addition, a pain indicator list for the cognitively impaired resident (Appendix C: Pain Indicator List for the Cognitively Impaired) can be used to detail specific facial expressions, body movements, physiological and autonomic responses and daily activities and unusual behaviours that may indicate the presence of pain.
 5. Initiate a written plan of care within 24 hours of admission based on resident's assessed condition and the location, type and patterns of pain episodes, previous history of pain and what was used to manage pain in the past (both pharmacological and non-pharmacological interventions), and contributing factors that may cause pain and allergies.
 6. Obtain informed consent for the treatment interventions from the resident/SDM.
 7. Complete the care plan within 21 days after admission and continue to update and adjust the care plan based on the RAI- MDS 2.0 assessment. The Pain, Cognitive Performance (CPS), and Communication (COM) scales will inform three (3) questions.

- Does the resident have pain (Pain Scale); its frequency (J2a) and intensity (J2b)?
 - Is the resident able to communicate the pain (COM)?
 - Is cognitive impairment affecting the ability to communicate (CPS)?
8. Implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions (e.g. positioning, distraction, relaxation, massage, aroma therapies, heat and cold).
 9. Obtain informed consent for treatment when establishing the initial care plan and making changes to the care plan from the resident/SDM.
 10. Document the effectiveness of the interventions.
 11. A pain monitoring flow sheet (Appendix D: Pain Monitoring Flow Sheet) can be used to monitor pain and determine the effectiveness of the pain management strategies over time.
 12. Monitor and evaluate the care plan at least quarterly and more frequently as required based on the resident's condition in collaboration with the interdisciplinary team. If the interventions have not been effective in managing pain, initiate alternative approaches and update as necessary.
 13. Consider referral to a palliative care team and or symptom management consultant for pain that is not well controlled.
 14. Communicate to the team and the resident/SDM whenever there is a significant change to the care plan regarding pain prevention on an ongoing basis and annually at the care conference.

Interdisciplinary Team:

1. Follow the interventions as outlined on the care plan.
2. Recognize and report resident verbalizations and behaviors indicative of discomfort/pain.
3. Report decrease in any of the following: physical and social activity, energy, appetite, continence and sleeping patterns.
4. Share with team members resident interventions that are most effective.
5. Encourage maintenance/restorative/supportive care measures as supported through pain management approaches.
6. Support resident comfort and interests.

Physiotherapist/Occupational Therapist:

1. Implement system assessments as appropriate for musculoskeletal and neurological conditions and contributing pain factors.

2. Develop and implement therapeutic interventions for the assessed conditions.
3. Evaluate and advise the interdisciplinary team of the impact of pain on mobility and Activities of Daily Living (ADL) status and recommend assistive mobility and adaptive aids.
4. Work with resident/SDM to plan and ensure seating and mobility comfort.
5. Encourage resident independence as tolerated.
6. Work with external companies in relation to seating and mobility devices.
7. Work with resident and SDM to ensure that equipment remains in good condition.
8. Educate resident and SDM on approaches that support pain management and resident comfort.

Physician/RN Extended Class:

1. Review medications.
2. Obtain informed consent for the treatment from the resident and or the SDM.
3. Ensure that the selection of analgesics is individualized to the person, taking into account:
 - the type of pain (acute or chronic, and or neuropathic)
 - intensity of pain
 - potential for analgesic toxicity (age, renal impairment, peptic ulcer disease, thrombocytopenia)
 - general condition of the resident
 - concurrent medical conditions
 - response to prior or present medications.

Dietician:

1. Complete nutritional risk assessment.
2. Suggest adequate fluid and diet intake to reduce the possibility of constipation.

Resident/SDM:

1. Attend the interdisciplinary care conference.
2. Work with staff for input into, support and evaluation of the plan of care.

Monitor and Evaluate

Registered Nursing Staff:

Individual Resident

1. Monitor according to the care plan.
2. Continually monitor resident verbalizations and behaviors indicative of discomfort/pain.
3. Evaluate to determine if pain strategies are effective. Are changes to the care plan required?

Evaluate Policy Effectiveness Annually

1. Perform an analysis of the available data related to the pain management program. The type of information to be used in the analysis of the policy may include:
 - Care plan, RAI-MDS 2.0 data and clinical indicators.
 - Trends in data recorded on internal tools such as Appendix B: Pain Assessment Tool.
2. Annually evaluate the effectiveness of the policy for managing pain and identify the changes and improvements that are required in the program to improve and maintain optimal functional level and quality of life among residents, and to ensure compliance with the LTCHA and Regulation.

Documentation and Parties Responsible

The following table describes the various forms of documentation required and the parties responsible.

Documentation	Parties Responsible
Informed consent	Physician, RNEC, others to be determined
Written order	Physician, RNEC
Pain Screening Tool	Registered Nursing Staff
MDS-RAI 2.0	Registered Nursing staff for measureable objectives and outcomes
Pain Monitoring Flow Sheet	Registered Nursing Staff and other Direct Care Staff (HCA/PSW, Activation/ Recreation)
Care plan	Registered Nursing Staff, Interdisciplinary Team
Quarterly reassessment	Physician, RNEC, Registered Nursing Staff
Annual evaluation of the effectiveness of the policy and improvement introduced resulting from the evaluation	Multidisciplinary Team

Staff Orientation and Training

Orientation and training may include the following:

1. Self-Learning Package (Appendix E: *Assessment and Management of Pain in the Elderly: Self-directed learning package for nurses in long-term care*).
2. Pain Management Training Materials (Appendix F: Pain Management Training Material, Appendix G: Pain Management Program Training Presentation for Regulated Staff, and Appendix H: Pain Management Program Training Presentation for Unregulated Staff).
3. Other as deemed necessary by the home.

Staff Orientation

Prior to assuming their job responsibilities, direct care staff must receive training on pain management including pain recognition of specific and non-specific signs of pain.

Training

Direct care staff must receive annual retraining on pain management including pain recognition of specific and non-specific signs of pain.

References

Belmont House, Toronto

Grey Bruce Palliative Care/Hospice Association Manual. Brignell, A. (ed) (2000). Guideline for developing a pain management program. A resource guide for long-term care facilities, 3rd edition.

Huron Lodge, The Corporation of The City of Windsor

Registered Nurses Association of Ontario (2002). *Assessment & Management of Pain*. Toronto, Canada: Registered Nurses Association of Ontario.

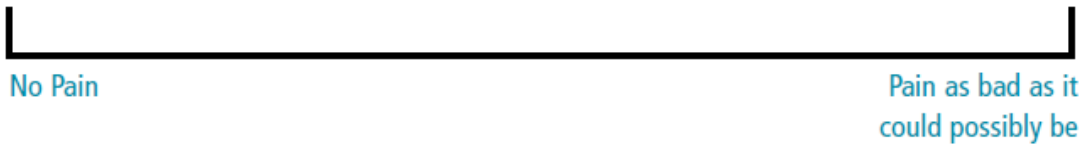
Registered Nurses Association of Ontario (2007). *Assessment and Management of Pain in the Elderly: Self-directed learning package for nurses in long-term care*. Toronto, Canada: Registered Nurses Association of Ontario.

Ukrainian Canadian Care Centre

Welland Hospital Extended Care

APPENDIX A: PAIN SCALES

SAMPLE 1 – Visual Analogue Scale (VAS)



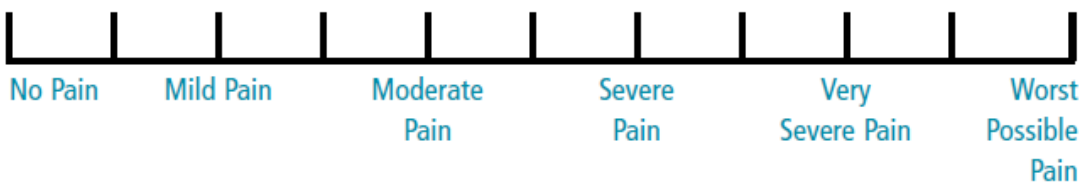
The patient indicates intensity of pain on a 10cm. line marked from no pain at one end to pain as bad as it could possibly be at the other end.

SAMPLE 2 – Numeric Rating Scale (NRS)



The patient rates pain on a scale from 0 to 10.

SAMPLE 3 – Verbal Rating Scale (VRS)



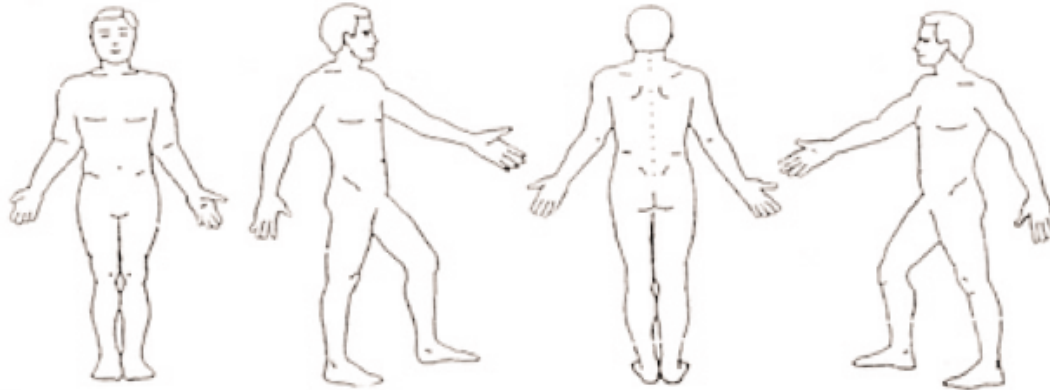
The patient rates the pain on a Likert scale verbally, e.g. "none", "mild pain", "moderate pain", "severe pain", "very severe pain" or "worst possible pain".

Reference: Registered Nurses Association of Ontario (2002). Assessment & Management of Pain. Toronto, Canada: Registered Nurses Association of Ontario.

APPENDIX B: PAIN ASSESSMENT TOOL

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 it's least?				
What makes the pain worse?				
What is the rate when the pain is at it's 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: Indicate the words that describe the pain using the letter of the pain (A,B,C) being described.

- Aching throbbing shooting stabbing gnawing sharp
 burning tender exhausting tiring penetrating numb
 nagging harrmering miserable unbearable tingling stretching
 pulling other: _____



0
no pain



2
mild



4
discomforting



6
distressing



8
horrible



10
excruciating

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 program. A resource guide for long-term care facilities, 3rd 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)

1. _____ 2. _____ 3. _____ 4. _____

Signature: _____ Date: _____

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 program. A resource guide for long-term care facilities, 3rd edition.

Key for Pain Assessment Tool

Location of Pain:

As indicated, have the resident, or if necessary, you can place the letter "A" on the part of the body where the resident reports feeling pain. If the pain starts at a certain point then travels, you can indicate the direction and extent of the travel with an arrow. If it seems that there could be a second or third pain, then use the letters "B" and "C".

Intensity:

The resident will be requested to answer the questions in the table as they relate to each identified pain. The preferred pain tool is 0-10. If the resident is finding this confusing or is unable to comply, then use the facial grimace scale as an objective measure.

Quality:

Go over each pain location to identify the appropriate descriptors from the list or if the resident has a different descriptive word, record this beside "other". Indicate the letter that corresponds to the location of pain being described beside the descriptive words.

Effects of pain on activities of daily living (ADL's):

You want to find out if any of the pains identified in the "location of pain" and "intensity" section are affecting any of the activities of daily living listed. Tick "yes" or "no".

If pain is causing a problem in any of the ADL's, indicate in the comments column which pain is causing the problem and in what way.

If pain were not causing a problem in the activity but the resident expresses a difficulty because of some other problem or symptom, you would tick no, but include a comment to elaborate.

It is also important to know if the resident feels that help is needed with any of the activities identified as a problem or if they are content to live with it. If the resident wants help, this would then suggest a need to refer to the appropriate person.

The following are some additional questions and/or points that you may find helpful when asking about the specific ADL areas. Also, included are possible *referrals to the professional(s), who are experts in the different areas.

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1. Sleep and Rest:

Ask - How often do you wake in the night? How many nights of the week? What is a good or bad night
What position do you sleep in? Do you use any special positioning devices?
Have you tried any in the past? Did they work?

*OT/PT/RN/DR/PC/SW

2. Social activities:

Includes leisure (hobbies), recreational activities, shopping.

*OT/SW/Volunteers.

3. Appetite:

Number and size of meals taken. Food preferences, snacks, an example of how each might help.

*Dietitian

4. Physical activity and mobility:

Moving in bed; transfers to bed, chair, toilet; stairs; walking; other exercise; sports; personal care; bathing;
dressing, grooming, eating; medication management.

*OT/RN

5. Emotions:

Any change, as a result of the pain, and if so, is this significantly interfering with activities so that
intervention would be helpful.

*SW/PC/Volunteer

6. Sexuality and intimacy:

Is the pain resulting in a significant reduction in desire for sexuality/intimacy or making
the physical movement required too painful? In both cases, is this a concern for the resident?

*SW/PT/OT/RN/DR

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program. A resource guide for long-term care facilities, 3rd edition.

Effects of pain on your quality of life:

This can be a very difficult subject to try to describe, which is why some descriptors have been included to assist the resident: happiness, contentment and fulfillment. Have the resident indicate which activity can no longer be done that is important to him/her. Ask how we can help.

Current Medications and Usage:

Include all medications and how ordered; dose, times, number of tablets, how effective using 0-10 scale, regular or PRN, side effects.

Family Support:

This can be any person who is involved in the resident's life and is recognized by the resident as a "significant other".

Symptoms:

Have the resident identify from the listed symptoms which ones are affecting his/her quality of life. Check appropriate ones.

Behaviours:

Have the resident identify disturbing behaviours if possible and/or the assessor will identify and check exhibited behaviour(s).

Past pains:

Have the resident describe the pain incident and his/her coping methods.

Nursing pain diagnosis:

Considering all the information from the assessment, identify one or more pains.

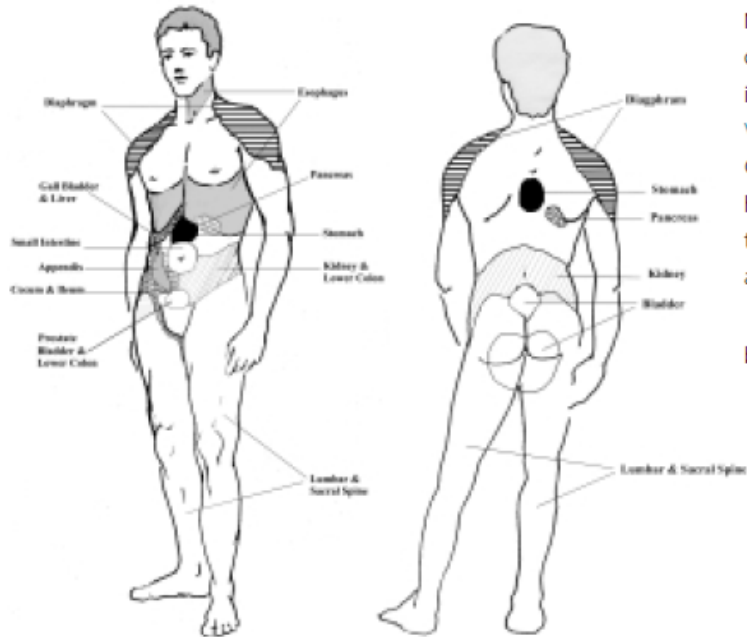
Assign the corresponding letter to relate them to the pains identified in the "Location of Pain" section.

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Pain Diagnosis:

There are four classifications of pain; nociceptive pain, neuropathic pain, mixed pain and pain of unknown origin.

Examples of referred pain



Illustrated by: Nancy A. Bauer, BA, Bus. Admin., RN, ET

Reference: [(Phipps, Long & Wood, 1995), cited in McCance & Huether, 1998; Venes, D. 1997]

1. Nociceptive:

Nociceptive pain is caused by tissue damage created by pressure, infiltration or destruction by an identifiable somatic or visceral lesion.

Visceral:

Constant, dull, aching, poorly localized pain that has a gradual onset often felt at a distance from the origin.

a) Solid Viscera (eg: liver, pancreas)

- if intense, can be sharp and penetrating

b) Hollow Viscera (eg: bowel, bladder)

- diffuse, or colicky pain
- feeling of pressure or fullness caused by blockage of previously open "tunnel"
- may have shortness of breath or cough with thoracic viscera; abdominal distention, nausea, vomiting with abdominal viscera.

Somatic:

Constant gnawing or aching, usually well localized, worse on movement or weight-bearing if in pelvis, hips, femur, joints or spine.

- bony metastases
- skin invasion or ulceration
- muscle invasion, soft tissue masses
- pathologic fractures
- osteo-arthritis and other bone destructive diseases
- may be present in back and shoulder if it involves T1

Raised intracranial pressure:

- brain tumours
- meningeal carcinomatosis

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2. Neuropathic:

Neuropathic pain is caused by pressure, invasion or destruction of peripheral or central nervous tissues, which leads to complex and abnormal spinal cord or thalamic neural processes that produce sustained pain.

- invasion, destruction of lumbosacral or brachial plexus
- spinal cord compression
- pain often precedes sensory and motor loss
- constant ache to intermittent, sharp stabbing pain
- specific nerve root compression may cause dermatomal pain
- progressive damage may result in superficial burning pain
- can experience hyperaesthesia, dysaesthesia, progressive motor and sensory loss
- can have vasomotor changes

3. Mixed:

Mixed pain in many instances is a combination of nociceptive and neuropathic pain.

- tumour invasion of pancreas with spread to and destruction of vertebra including spinal cord compression.

4. Unknown:

Persistent pain, the cause of which cannot be determined by history and investigations.

- may be described with all the current word descriptors
- patient is often not believed if investigations are inconclusive
- is usually under treated
- can be debilitating
- lifelong suffering may lead to depression

Problem List:

Using the "Pain Assessment Tool" circle the pain diagnosis(es) and list them on the care plan. If you identify a problem that the resident did not, it is important to ensure the resident agrees and understands why this is a problem. This is an ongoing list. Please date each problem when identified and resolved.

Goals and Plans:

From the problem list, the resident creates goals and you work together to identify the interventions.

It is important to include who specifically will do what and to whom the resident has been referred.

Also, include what outcome measure you will be using to re-evaluate the goal i.e. analog scale of 0 -10 and what tool you will use if it is other than pain. i.e. 0 = no nausea, 10=worst nausea imaginable; or scores from the behaviour checklist.

Include when you anticipate the plans to be carried out and when you will be re-evaluating the goal.

Make sure to sign and date each entry.

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APPENDIX C: PAIN INDICATOR LIST FOR THE COGNITIVELY IMPAIRED

Resident Name: _____ Annual Date: _____
Reviewed: _____
Quarterly: _____

Use this checklist with the "Pain Monitoring Flow Sheet" form (see Appendix D: Pain Monitoring Flow Sheet).

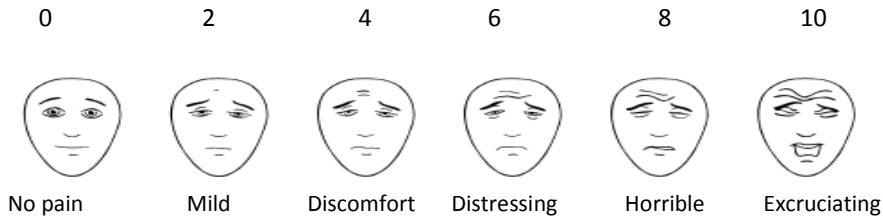
- Check the indicators observed in the cognitively impaired resident.
- Other: _____

Vocalizations			
	Calling out e.g. "help me, help me", "nurse, nurse"		
	Moaning/whimpering/groaning		
	Crying		
	Angry outbursts triggered by sensory stimulation (e.g. resisting care, striking out when being transferred or bathed)		
Facial Expressions/Body Movements			
	Frowning		Rigid posture
	Tightly closed eyes		Guarding body part
	Widely opened eyes		Hand tension (finders crossed)
	Tightly closed mouth		Fidgeting
	Widely opened mouth		Rocking
	Grimacing (facial strain)		Pacing
	Clutching or rubbing a body area		
Physiological/Autonomic Responses			
	Rapid, shallow breathing		Local tenderness to touch
	Pallor/blanching		Swollen joints
	Perspiration		Weakness
	Increased heart rate		Tremor
	Nausea/vomiting		Hypersensitivity (heat, cold, pressure, weather change)
	Listless		Impaired chewing ability and speech
	Chronic regurgitation/belching		Weight loss
	Abdominal bloating		Startle response
	Weight gain		Edema
Daily Activities and Usual Behaviours			
	Sleeplessness		Resistance to joint movement
	Decreased appetite		Avoids noise
	Decreased activity levels		Avoids light
	Restlessness		Avoids movement
	Frequently waking up at night		Avoids standing
	Mood swings		Avoids walking

	Wanting to sleep all day		Avoids gentle exercise
	Stiffness in morning		Intolerance to bedclothes
	Stiffness after activity		Intolerance to clothing
	Loss of interest in social activities		Intolerance to touch
	Intolerance to bathing		
Initials		Initials	

Source: Huron Lodge, The Corporation of the City of Windsor

APPENDIX D: PAIN MONITORING FLOW SHEET



Name _____

Date	Time	Pain Rating	Analgesic Drug/ Dose	# of Breakthrough(s)	Sedation	Activity	Complementary Theory	Other Observations & Comments & Descriptions (Analgesic / Steroids)	Nonverbal Behaviours	Emotions	Progress Note	Initials

- | | | | | |
|--|--|---|---|--|
| Sedation:
NS – normal sleep
A – awake
OD – occasional drowsy, easy to arouse
FD – frequently drowsy, easy to arouse
S – somnolent, difficult to arouse | Activity:
BR – bed rest
C – chair
A – ambulatory | Complementary Therapy:
AC – acupuncture
RP – repositioned
H – heat
C – ice packs
M – massage
TT – therapeutic touch
CS – coetaneous stimulation | Nonverbal Behaviour:
G – grimace
M – moaning
R – restless
MC – myoclonus
Del – delirium | Emotions:
A- anxiety
W – weepy
AG - agitated |
|--|--|---|---|--|

Source: Huron Lodge, The Corporation of the City of Windsor

APPENDIX E: ASSESSMENT AND MANAGEMENT OF PAIN IN THE ELDERLY

For Appendix E: *Assessment and Management of Pain in the Elderly: Self-directed learning package for nurses in long-term care*, see attached PDF (Adobe PDF file) included in this package.

APPENDIX F: PAIN MANAGEMENT TRAINING MATERIAL

For Appendix F: Pain Management Training Material, go to <http://www.managingpaintogether.ca>.

APPENDIX G: PAIN MANAGEMENT PROGRAM TRAINING PRESENTATION FOR REGISTERED STAFF

For Appendix G: Pain Management Program Training Presentation for Registered Staff, see attached presentation (Microsoft PowerPoint file) included in this package.

APPENDIX H: PAIN MANAGEMENT PROGRAM TRAINING PRESENTATION FOR UNREGULATED STAFF

For Appendix H: Pain Management Program Training Presentation for Unregulated Staff, see attached presentation (Microsoft PowerPoint file) included in this package.