WHITING FORENSIC HOSPITAL

OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Assessment
PROCEDURE 2.5:	**Assessment and Management of Pain**
Governing Body Approval:	April 11, 2018
REVISED:	

PURPOSE: To ensure that each patient is assessed and treated for pain on an ongoing basis throughout his/her hospital stay. The goal of pain management is to achieve optimum levels of pain relief and patient functioning.

SCOPE: All Physicians, Physical Therapists, Psychologists, Occupational Therapists, Dentists, Podiatrist, Optometrists, PAs, RNs, LPNs, & APRNs

POLICY:

In accordance with the rights of patients to appropriate assessment and management of pain, it is the policy of Whiting Forensic Hospital (WFH) that the physiological and psychological well-being of each patient is optimized.

PROCEDURE:

I. Assessment of Pain

A. When the Registered Nurse, Physician, APRN, GMS clinician, Dentist or Consultant assesses the patient for pain, they consider the following assessment factors:

1. severity of pain;
2. location of pain;
3. sensory quality of pain;

4. onset, duration, and temporal pattern;
5. aggravating factors;
6. alleviating factors;
7. effect of pain on the level of functioning (e.g., sleeping difficulties, changes in mood, interpersonal relationships, appetite, or activities of daily living);
8. current treatment of pain and its effectiveness;
9. patient's goal for relief of pain (e.g., decrease intensity, improve sleep, appetite, level of functioning, mood);
10. behavioral factors signaling pain or discomfort such as insomnia, constipation, crying, moaning, or sighing especially if the patient cannot verbally express the presence of pain due to cognitive impairment or psychosis;
11. physical examination of the patient/pain site; and
12. assessment of pain associated with chemical dependency/detoxification to differentiate between the pain associated with substance withdrawal and pain due to unrelated/co-occurring medical issues.

B. When the Registered Nurse, Physician, APRN, GMS Clinician, Dentist or Consultant making the assessment asks the patient to rate, the degree of pain using a standardized pain rating scale guide. The patient is asked to assess his/her pain using a 1-10 Numeric Scale. Using the scale allows the clinician to quantify a pain baseline, to which he/she can refer when evaluating the effectiveness of treatment prescribed.

C. In those instances in which a patient is unable to provide reports of pain or is nonverbal, pain assessment shall be assessed using the Face, Legs, Activity, Cry, Consolability (F.L.A.C.C.) Pain Assessment Tool. Whenever there is a need to utilize the FLACC Scale due to the patient's condition, this shall be noted as a Nursing Intervention on the patient's plan of care.

D. The Registered Nurse records the assessment of the patient for pain on admission and annually on the appropriate Admission Nursing Assessment (WFH-171 and WFH-519) form and the Annual Nursing Re-Assessment (WFH-171a) form. Assessment of pain during the hospital stay is documented in the Progress Notes.

E. The GMS Clinician records the assessment of the patient for pain on admission and annually on the Admission and Annual History and Physical Examination Form in the Review of Systems section. Assessment of pain during the hospital stay is documented by all clinicians in the Progress Notes.

F. If, after the assessment of pain, the Registered Nurse ascertains that pain is present, the Registered Nurse confers with the Attending Psychiatrist and GMS Clinician to develop a plan for assessment and treatment of pain.

G. This would include making every effort to engage the patient, his/her family, and significant others in the assessment process. This includes assessment of patient preferences for intervention with respect to pain management.

H. Prior relevant medical records should be obtained.

I. The Licensed Independent Practitioner (LIP) obtains additional evaluation information by ordering appropriate diagnostic studies and/or consultation, as indicated.

II. Treatment/Management of Pain

A. Upon review of the assessment data, the LIP develops a plan for reducing or eliminating pain including:

1. realistic goals for treatment/management are formulated ;
2. the patient's preferences for treatment are considered in determining methods for use in pain management and;
3. treatment is ordered and re-evaluated at intervals by the LIP.
4. Treatment/management may include pharmacological and non-pharmacological interventions (e.g., meditation, sensory-modulation techniques, relaxation techniques, cognitive-behavioral therapy interventions, occupational therapy, physical therapy, etc.)
5. If pharmacological interventions are utilized that have a potential for addiction or abuse; a careful review of past substance use behaviors, family history of substance use and the abuse potential of the medication must be assessed and a risk/benefit analysis will be conducted and documented in the medical record.

B. While the pain exists, the Registered Nurse reassesses the patient for pain until such time that the evaluating LIP indicates in the Progress Notes that maximal medical benefit has been achieved.

C. When medications and non-pharmacologic interventions for pain are utilized, the LIP and the Registered Nurse evaluate for:

1. the efficacy of the intervention;
2. the presence of side effects;
3. the potential need for medication dosage adjustments and/or interval of administration OR adjustment of the non-pharmacologic interventions; and
4. the need for supplemental doses of medication for breakthrough pain.

D. The results of this evaluation and the effectiveness of treatment interventions are documented in the Progress Notes by the LIP. The Nurse documents medications given and their effectiveness using a standardized pain rating scale (a 1-10 Numeric scale or other patient appropriate pain scale) on the PRN Medication and Omitted Doses area of the Medication Administration Record (MAR), and prescribed treatment interventions on the Treatment Record.

E. When interventions are planned for pain management, the GMS Clinician, Attending Psychiatrist, Registered Nurses, and/or other designated health care providers educate

patients and families about how the pain is being assessed and treated. This education is documented in the medical record.

F. The Attending Psychiatrist documents pain management interventions of an ongoing nature in the patient's Master Treatment Plan. The Registered Nurse initiates and maintains a nursing plan of care for pain management interventions of an ongoing nature.

G. All clinicians and other health care providers document the ongoing reassessment and patient response to treatment in the Progress Notes section of the medical record.

H. The Medical Director or Medical Provider is available to assist in the assessment process and for consultation.

I. The Attending Psychiatrist ensures that the patient's response to pain management interventions during the course of hospitalization and his/her referral for ongoing pain management are addressed in the discharge plan and, upon discharge, in the discharge documentation.

J. The Pain Management Committee will develop an annual Performance Improvement Plan in which the collaborative practices of the medical and nursing staff are monitored.

K. The Pain Management Committee will provide analyses of trends and recommendations for appropriate policy, procedural, and/or practice modifications to the hospital leadership.