PAIN MANAGEMENT DECISION-MAKING FRAMEWORK

for nurses and care staff caring for people with advanced dementia

GUIDELINES

BLUE MOUNTAINS GP NETWORK INCORPORATED
University of Western Sydney
SYDNEY WEST AREA HEALTH SERVICE | NSW HEALTH

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Disclaimer

These guidelines were written during the 'Decision-making frameworks in advanced dementia: Links to improved care' project, a partnership between the University of Western Sydney School of Nursing and Midwifery, College of Health & Science; Sydney West Area Health Service Primary Care & Community Health Network; and the Blue Mountains Division of General Practice. Funded by the Australian Government Department of Health and Ageing under the National Palliative Care Program. The opinions expressed in this document are those of the authors and not necessarily those of the Australian Government.

The information provided is a general guide only. Refer to the general practitioner and other members of the treatment team for decisions relating to care of individual residents. The information provided in these guidelines is based on the available best practice literature, or in the absence of this literature, expert opinion.

Figure 1

OVERVIEW OF THE PAIN DECISION-MAKING FRAMEWORK*

* This framework is for any **persistent** pain that is impacting on a resident's functional ability, psychosocial function, or quality of life.

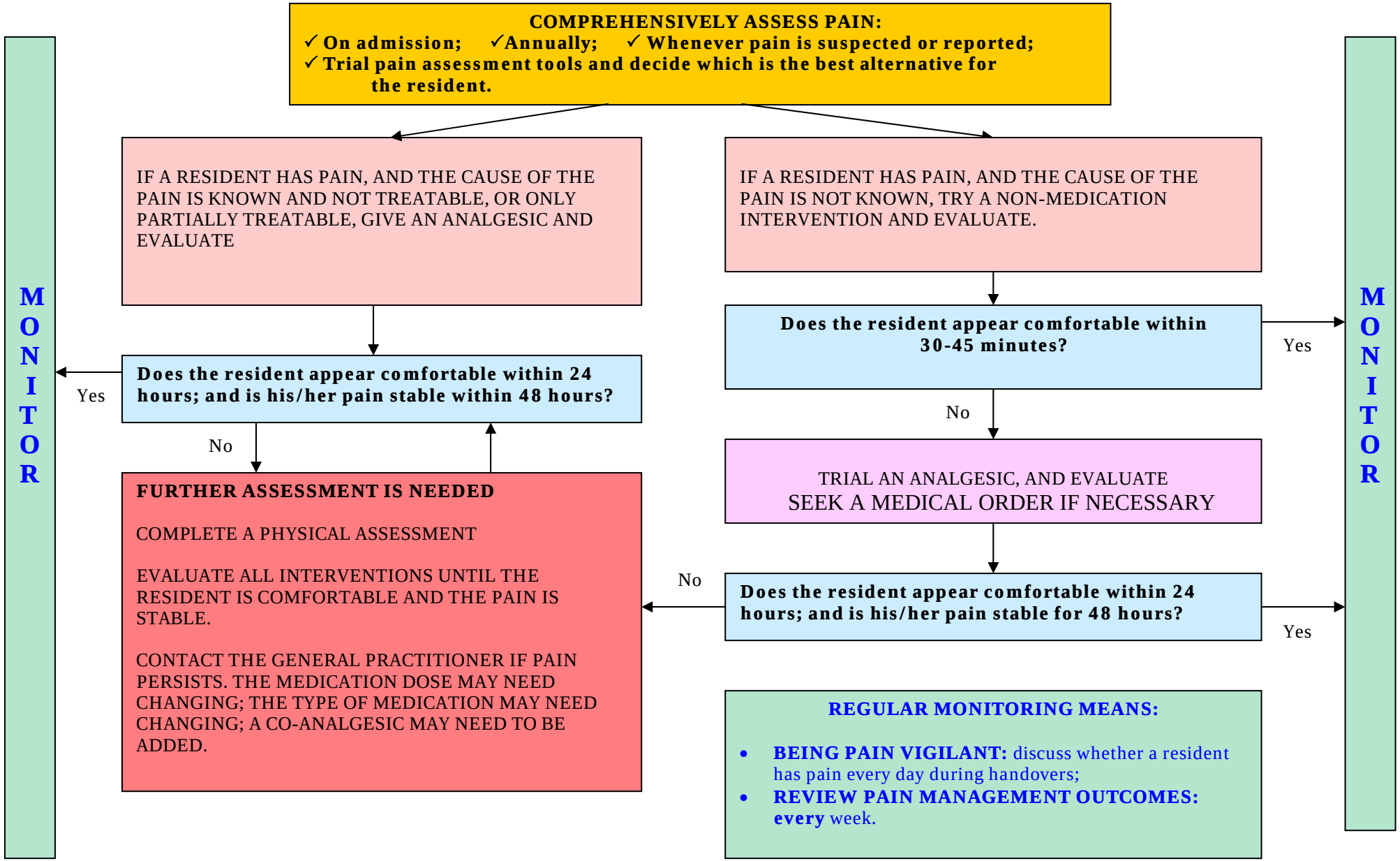

Figure 2

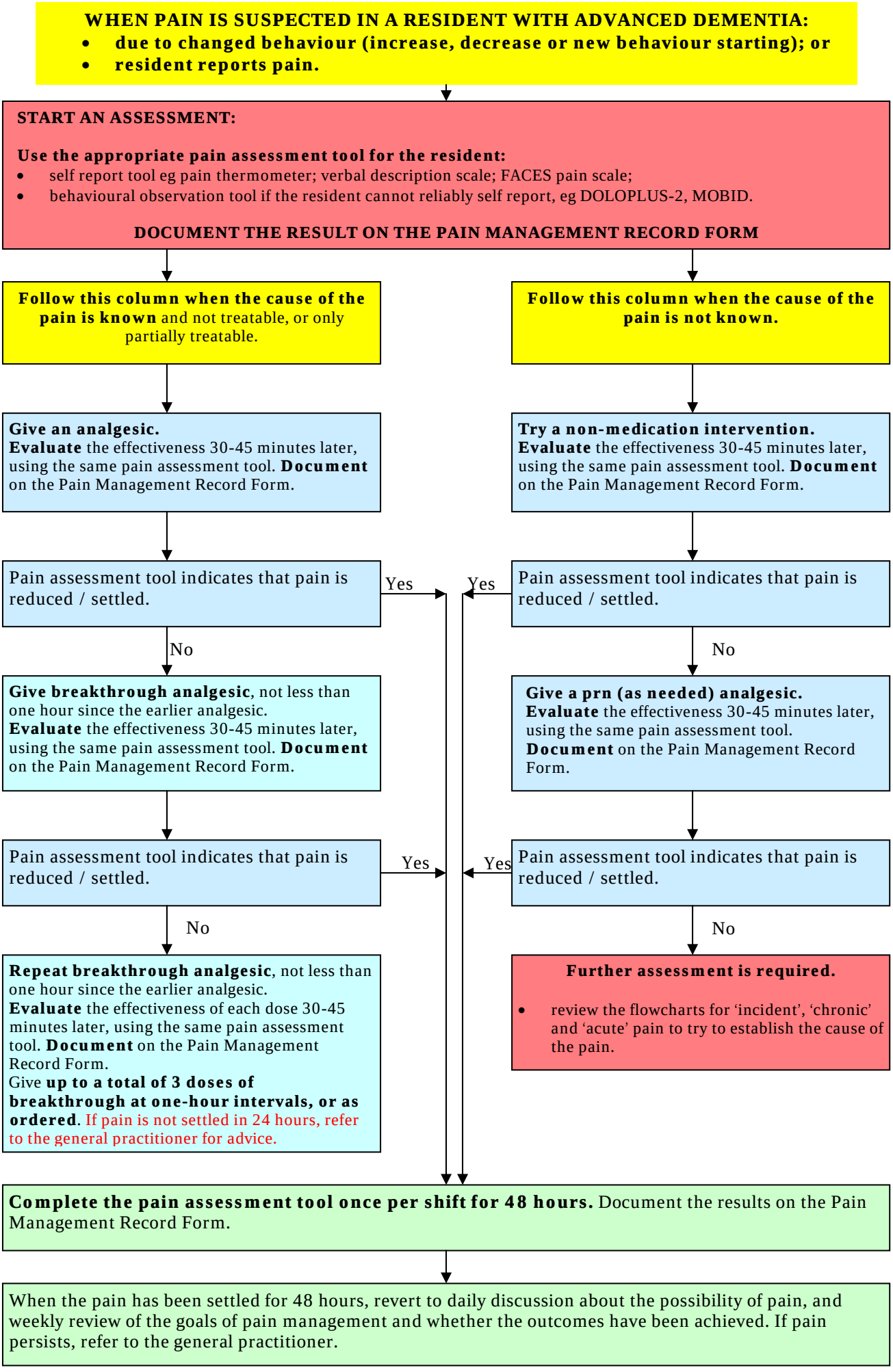
WHEN PAIN IS SUSPECTED IN A RESIDENT WITH ADVANCED DEMENTIA:
• due to changed behaviour (increase, decrease or new behaviour starting); or
• resident reports pain.
START AN ASSESSMENT:
Use the appropriate pain assessment tool for the resident:
• self report tool eg pain thermometer; verbal description scale; FACES pain scale;
• behavioural observation tool if the resident cannot reliably self report, eg DOLOPLUS-2, MOBID.
DOCUMENT THE RESULT ON THE PAIN MANAGEMENT RECORD FORM
Follow this column when the cause of the pain is known and not treatable, or only partially treatable.
Follow this column when the cause of the pain is not known.
Give an analgesic.
Evaluate the effectiveness 30-45 minutes later, using the same pain assessment tool. Document on the Pain Management Record Form.
Try a non-medication intervention.
Evaluate the effectiveness 30-45 minutes later, using the same pain assessment tool. Document on the Pain Management Record Form.
Pain assessment tool indicates that pain is reduced / settled.
Yes
Yes
Pain assessment tool indicates that pain is reduced / settled.
No
No
Give breakthrough analgesic, not less than one hour since the earlier analgesic.
Evaluate the effectiveness 30-45 minutes later, using the same pain assessment tool. Document on the Pain Management Record Form.
Give a prn (as needed) analgesic.
Evaluate the effectiveness 30-45 minutes later, using the same pain assessment tool.
Document on the Pain Management Record Form.
Pain assessment tool indicates that pain is reduced / settled.
Yes
Yes
Pain assessment tool indicates that pain is reduced / settled.
No
No
Repeat breakthrough analgesic, not less than one hour since the earlier analgesic.
Evaluate the effectiveness of each dose 30-45 minutes later, using the same pain assessment tool. Document on the Pain Management Record Form.
Give up to a total of 3 doses of breakthrough at one-hour intervals, or as ordered. If pain is not settled in 24 hours, refer to the general practitioner for advice.
Further assessment is required.
• review the flowcharts for 'incident', 'chronic' and 'acute' pain to try to establish the cause of the pain.
Complete the pain assessment tool once per shift for 48 hours. Document the results on the Pain Management Record Form.
When the pain has been settled for 48 hours, revert to daily discussion about the possibility of pain, and weekly review of the goals of pain management and whether the outcomes have been achieved. If pain persists, refer to the general practitioner.

Figure 3

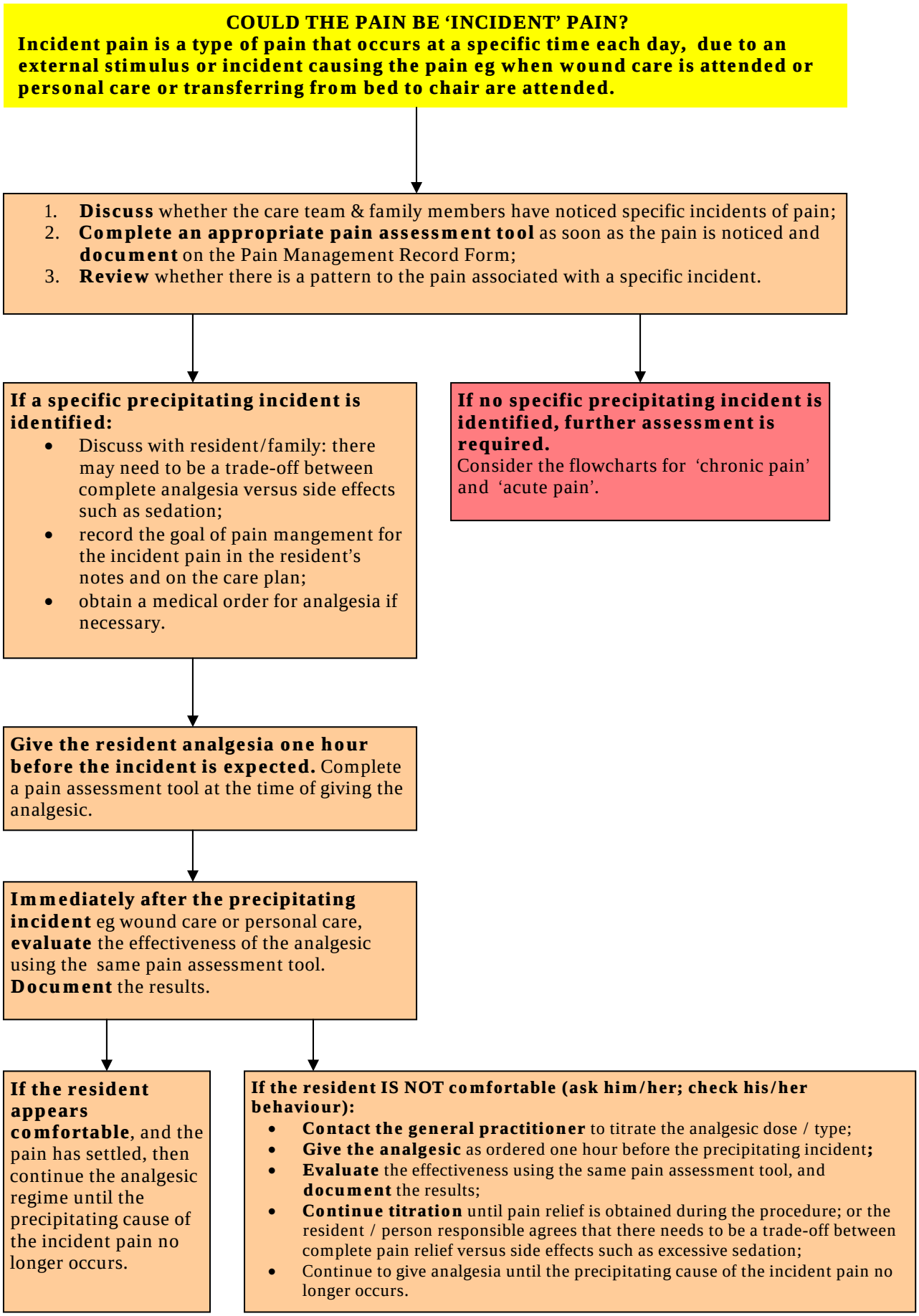
COULD THE PAIN BE 'INCIDENT' PAIN?
Incident pain is a type of pain that occurs at a specific time each day, due to an external stimulus or incident causing the pain eg when wound care is attended or personal care or transferring from bed to chair are attended.
1. Discuss whether the care team & family members have noticed specific incidents of pain;
2. Complete an appropriate pain assessment tool as soon as the pain is noticed and document on the Pain Management Record Form;
3. Review whether there is a pattern to the pain associated with a specific incident.
If a specific precipitating incident is identified:
• Discuss with resident/family: there may need to be a trade-off between complete analgesia versus side effects such as sedation;
• record the goal of pain mangement for the incident pain in the resident's notes and on the care plan;
• obtain a medical order for analgesia if necessary.
If no specific precipitating incident is identified, further assessment is required.
Consider the flowcharts for 'chronic pain' and 'acute pain'.
Give the resident analgesia one hour before the incident is expected. Complete a pain assessment tool at the time of giving the analgesic.
Immediately after the precipitating incident eg wound care or personal care, evaluate the effectiveness of the analgesic using the same pain assessment tool. Document the results.
If the resident appears comfortable, and the pain has settled, then continue the analgesic regime until the precipitating cause of the incident pain no longer occurs.
If the resident IS NOT comfortable (ask him/her; check his/her behaviour):
• Contact the general practitioner to titrate the analgesic dose / type;
• Give the analgesic as ordered one hour before the precipitating incident;
• Evaluate the effectiveness using the same pain assessment tool, and document the results;
• Continue titration until pain relief is obtained during the procedure; or the resident / person responsible agrees that there needs to be a trade-off between complete pain relief versus side effects such as excessive sedation;
• Continue to give analgesia until the precipitating cause of the incident pain no longer occurs.

Figure 4

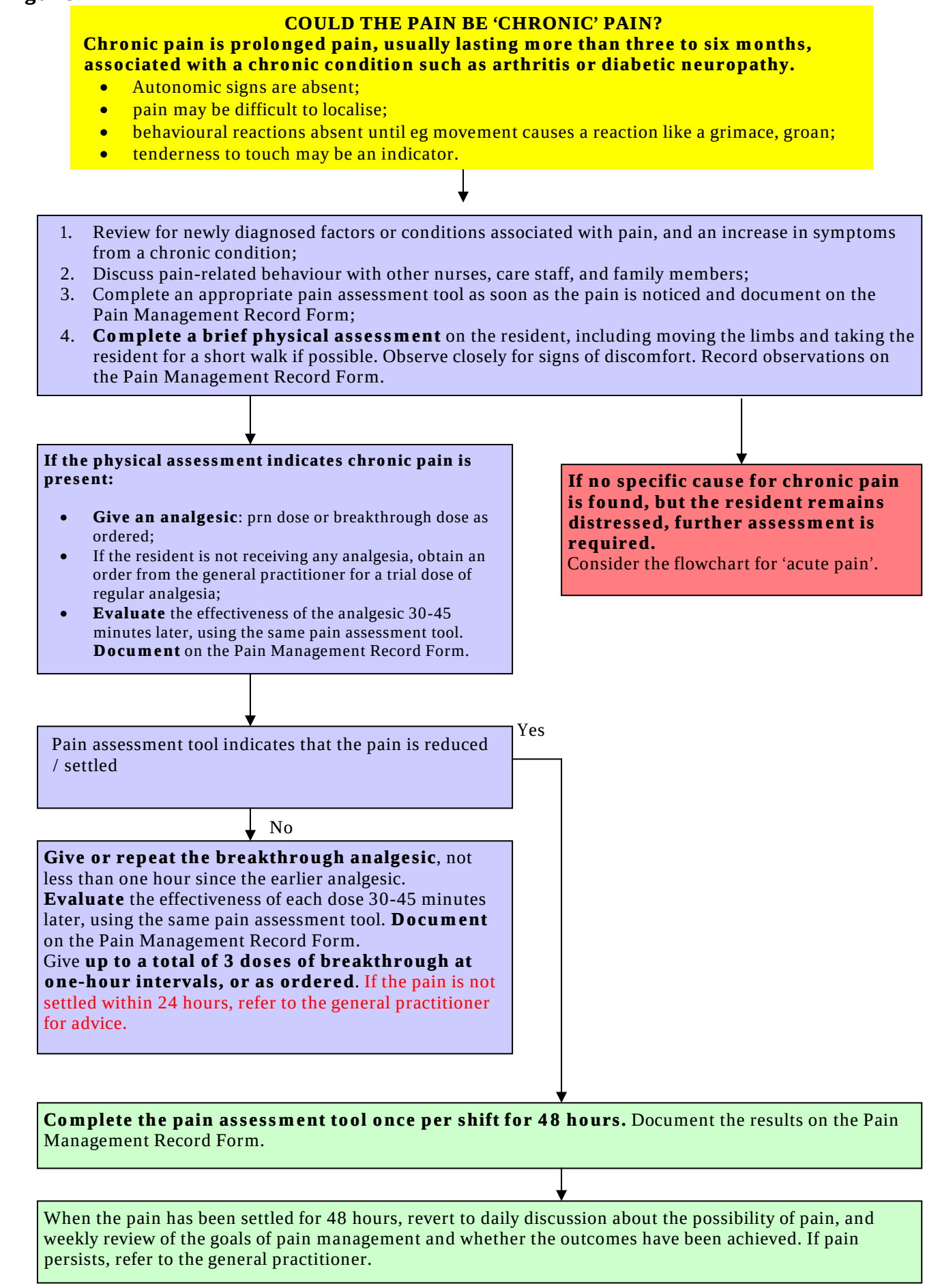
COULD THE PAIN BE 'CHRONIC' PAIN?
Chronic pain is prolonged pain, usually lasting more than three to six months, associated with a chronic condition such as arthritis or diabetic neuropathy.
• Autonomic signs are absent;
• pain may be difficult to localise;
• behavioural reactions absent until eg movement causes a reaction like a grimace, groan;
• tenderness to touch may be an indicator.
1. Review for newly diagnosed factors or conditions associated with pain, and an increase in symptoms from a chronic condition;
2. Discuss pain-related behaviour with other nurses, care staff, and family members;
3. Complete an appropriate pain assessment tool as soon as the pain is noticed and document on the Pain Management Record Form;
4. Complete a brief physical assessment on the resident, including moving the limbs and taking the resident for a short walk if possible. Observe closely for signs of discomfort. Record observations on the Pain Management Record Form.
If the physical assessment indicates chronic pain is present:
• Give an analgesic: prn dose or breakthrough dose as ordered;
• If the resident is not receiving any analgesia, obtain an order from the general practitioner for a trial dose of regular analgesia;
• Evaluate the effectiveness of the analgesic 30-45 minutes later, using the same pain assessment tool. Document on the Pain Management Record Form.
If no specific cause for chronic pain is found, but the resident remains distressed, further assessment is required.
Consider the flowchart for 'acute pain'.
Pain assessment tool indicates that the pain is reduced / settled
Yes
No
Give or repeat the breakthrough analgesic, not less than one hour since the earlier analgesic.
Evaluate the effectiveness of each dose 30-45 minutes later, using the same pain assessment tool. Document on the Pain Management Record Form.
Give up to a total of 3 doses of breakthrough at one-hour intervals, or as ordered. If the pain is not settled within 24 hours, refer to the general practitioner for advice.
Complete the pain assessment tool once per shift for 48 hours. Document the results on the Pain Management Record Form.
When the pain has been settled for 48 hours, revert to daily discussion about the possibility of pain, and weekly review of the goals of pain management and whether the outcomes have been achieved. If pain persists, refer to the general practitioner.

Figure 5

COULD THE PAIN BE 'ACUTE' PAIN?

Acute pain usually starts suddenly, may be severe, and is of a brief duration.

- autonomic signs are present eg sweating, tachycardia, nausea;
- behavioural signs are present eg grimacing, rubbing or resting the affected area;
- common reasons include infections, fractures, cancer and discomfort from constipation, bladder distension, pressure ulcers;
- residents with well-managed chronic pain can also develop acute pain in another site.

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Is the pain due to an acute cause?

- record the resident's vital signs: temperature, pulse, blood pressure, respirations;
- look for autonomic signs;
- complete a pain assessment tool before and after analgesia;
- review each of the common causes listed below, **give analgesia, either a prn dose, breakthrough dose, or obtain an order for a regular analgesic;**
- contact the general practitioner if necessary for treatment advice, and if the resident's condition deteriorates. Treatment will depend on the goals of care for the resident.

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Consider:

- **urinary tract infection?** (Urine smelly and cloudy? Nitrates and white blood cells present on urinalysis);
- **constipation?** (abdomen distended, stools hard, or faecal-stained fluid indicating possible impaction? Resident aggressive or more confused than usual);
- **chest infection?** (rate of respirations increased? resident lethargic, coughing, more confused than usual? aspirating silently (fever, no coughing?);
- **bladder distended?**
- **pressure ulcers?**
- **injury?**
- **other signs of illness that may be causing pain?**

↓

Give breakthrough analgesic as required. **Contact the General Practitioner if the pain is not settled within 24 hours**, to review the type of pain and dose / type of medication.

↓

Complete the pain assessment tool once per shift for 48 hours. Document the results on the Pain Management Record Form.

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When the pain has been settled for 48 hours, revert to daily discussion about the possibility of pain, and weekly review of the goals of pain management and whether the outcomes have been achieved. If pain persists, refer to the general practitioner.

Introduction to the Guidelines

These guidelines are for nurses and care staff to use when undertaking pain assessment and management in residents with advanced dementia (Mini Mental State Examination Score < 10). For additional information, please refer to the 'Supporting Information' provided with these guidelines. Training information to assist with education in residential aged care facilities is also available.

NB: Registered nurses remain responsible for the assessment and care of residents at all times, even if they delegate tasks to other staff members to complete.

On admission of a person with advanced dementia

1. **Give the person responsible +/- other family members a copy of the booklet: '*Dementia information for carers, families and friends of people with severe and end stage dementia*'. 2nd edition.**

2. **Identify the goals of care.**

Discuss with the person responsible +/- family members, general practitioner and other members of the care team what the goals of care are. Goals of care should be discussed at every family conference relating to the resident's clinical care. Is the resident to receive:

- active interventions, when you will look for and treat all causes of pain; or

- a palliative approach, where you will carefully look for and treat wherever possible the causes of pain, and otherwise provide sufficient analgesia to keep the resident comfortable, unless there is an agreement that there needs to be a trade-off between complete pain relief versus side effects such as excessive sedation. Care is focussed on maintaining the quality of life and comfort of the resident. Assessment for causes of pain will continue unless the person responsible and general practitioner +/- family members agree that limited assessment only will be undertaken. Care that focuses on the resident's comfort, psychological, social and spiritual needs, and the needs of the person responsible and family members are always provided as part of the palliative approach; or

- end of life (terminal) care, when death is likely to occur in the next days or weeks, and you will focus on resident comfort, and provide emotional support to the person responsible and family members.

The goals of care for a person with advanced dementia who experiences pain should be realistic due to the progressive nature of the dementia. The focus of the goal of care relating to pain management should be to treat or minimise any painful conditions possible by using adequate analgesia, so the resident can maintain as much independence as possible, and participate in activities he/she enjoys. In the final days of life, the goal of care is to maintain comfort without invasive interventions. Page 16 of the 'Supporting Information' contains further information relating to goals of care for pain management.

Document the goals of care in the resident's notes and on the care plan.

3. Gather baseline data: Assess the medical and pain history of the resident.

- Complete a full medical history. Refer to the admission notes; hospital discharge summaries and other documentation as available;

- document a list of all the known factors and conditions the resident is known to have that cause pain. A Comprehensive Pain Assessment Form is provided at the back of this document, to use if your facility does not have a similar form;

- record the location, description and effects on the resident's life of pain. Ask the resident if possible (self report of pain is the most accurate);

- if the resident is unable to self-report, ask others that know the resident well about behaviours that might indicate pain; whether the pain may be constant or intermittent, and when it is most likely to occur; what aggravates the pain; what appears to relieve the pain, and settle the resident; whether the pain is interfering with the resident's quality of life (eg activity, mood, walking ability, interactions with others, sleep, enjoyment of life);

4. Undertake a physical assessment for pain

Complete a physical examination for pain. Refer to the procedures section in this document for a procedure to use. Note that physical assessment has been found to be a more reliable way of assessing pain than using behavioural observation tools for residents unable to self-report their pain [1]. Document the findings on the Comprehensive Pain Assessment Form.

5. Determine which pain assessment tool(s) are appropriate for the resident

Self-report is the most accurate method of establishing the presence of pain, and the only method of establishing the intensity of pain. A valid pain assessment tool used regularly will provide evidence of the resident's pain experience and the effectiveness of pain management interventions. Use of behavioural observation tools results in underestimation of the amount of pain being experienced[2], and may contribute to undertreatment of pain [3].

Refer to the procedures section in this document for a procedure to use to trial pain assessment tools;

- Trial one or two self-report tools. If the resident is unable to complete them, nominate which of the behavioural observation tool(s) the facility will adopt for use for this resident.

Document the findings on a pain assessment form, such as the Comprehensive Pain Assessment Form.

6. Monitor the resident's pain for 7 days

- use the pain assessment tool(s) to monitor the resident's pain once per shift (morning, evening & night) for 7 days to establish a baseline measurement of the level of pain felt by the resident. Document the scores on a pain management record form. An example form is provided at the back of this document, to use if your facility does not have a similar form.

Seek advice from the general practitioner, and/or a physiotherapist or other health professional if there are problems associated with pain or functional ability. Further assessment of the causes of pain may be required.

NB: A general practitioner can contribute to a care plan and be paid under Medicare item 731. Once an item 731 has been claimed by the general practitioner, and it is documented that the resident requires allied health or dental services the resident may be eligible for up to 5 allied health and 3 dental care services per year.

STOP: LIMIT FURTHER ASSESSMENTS IF:

- the goal of care is for end of life (terminal) care; or

- the goal of care is a palliative approach, and during the goals of care discussion it is agreed that further assessment of the causes of pain will be limited.

Limited assessments mean:

- no pathology tests to establish the causes of pain;
- no X-Rays to establish the causes of pain;
- no other diagnostic tests to establish the causes of pain;

The following assessments and care WILL CONTINUE:

- monitoring and recording pain and the effectiveness of interventions to relieve pain, until the resident has been comfortable for 24 hours, and the pain has been stable for 48 hours;
- giving both regular and 'as needed' analgesics to keep the resident comfortable, including giving strong opioids where indicated and ordered.

If the resident is receiving end of life (terminal) care:

- assess the resident's level of consciousness and ability to swallow at least daily before offering food & fluids. If the resident is unable to swallow, offer appropriate mouth care only. Continue to give analgesia as ordered even if the resident appears comatose.

DOCUMENT the reasons for any decision to limit further assessments in the resident's notes. Make sure the care plan reflects the goals of care.

7. Develop a pain management plan based on the needs & preferences of the resident.

This completes the pain management section of the admission.

Monitoring

Registered nurse or delegate:

- discuss with the care staff whether the resident is showing signs of pain, or complaining of pain, daily during handovers and at nurses meetings;
- give analgesics as ordered;
- sign the 'Weekly Outcomes Review' (a copy is provided at the back of this document, to use if your facility does not have a similar form) after discussion with available family members and care staff. The adoption of the 'Weekly Outcomes Review' form will assist facilities to meet the accreditation standard relating to the satisfaction of resident's family members with the facility's approach to managing the resident's pain needs [4].

Pain assessment tools need to be used:

- whenever the resident experiences persistent pain, before and after each pain management intervention, until the pain settles;

- once the resident is comfortable and the pain is settled, use the appropriate tool to monitor the resident for 48 hours. Direct the care staff to complete the pain assessment tool once per shift. Document on the pain management record form.

Administering Analgesia

Refer to the 'Supporting Information' for information about the types and routes of administration of analgesics.

Procedures for the administration of transdermal patches and insertion of subcutaneous cannulae are in the back of this document.

NB All analgesics need a medical order before administration. Some 'simple' analgesics may be nurse-initiated: refer to your facility's policy.

The Framework

An overview of the framework can be found in Figure 1 in this document.

1. If the resident has persistent pain and the cause of the pain is known (Figure 2)

Registered nurse or delegate:

- direct the care staff to complete the appropriate pain assessment tool for the resident;
- give an analgesic, and evaluate 30-45 minutes later, using the same pain assessment tool. Document on the pain management record form;
- if the pain has settled, observe the resident for 48 hours. Direct the care staff to complete the pain assessment tool once per shift to monitor the pain. Document on the pain management record form;
- if the pain does not settle with the first dose of analgesic, give a breakthrough ('prn') dose not less than one hour since the earlier dose;
- evaluate 30-45 minutes later, using the same pain assessment tool. Document on the pain management record form;
- give up to a total of 3 breakthrough doses at one hour intervals, or as ordered. Evaluate the effectiveness of each dose of analgesic 30-45 minutes after the dose, using the same pain assessment tool. Document on the pain management record form;
- inform the care staff of any side effects that may occur, and direct the care staff to notify you if there are signs of side effects from the medication;
- if pain persists for 24 hours, contact the general practitioner. The dose of analgesic may need to be changed, the type of analgesic may need to be changed, or a co-analgesic may need to be added;
- direct the care staff to continue completing the same pain assessment tool until the resident's pain has been stable for 48 hours, then revert to daily discussion and signing the 'Weekly Outcome Review' form.

Care staff:

- be pain vigilant: observe the resident closely when undertaking personal care and interacting with the resident;
- report signs of pain to the registered nurse (RN) or nurse in charge. Use the NOPPAIN tool if your facility endorses its use;
- complete a pain assessment tool when pain is observed, or when the RN directs you to;
- report any side effects of medication, as directed by the RN or nurse in charge;
- participate in discussions about residents' pain at handovers and meetings.

2. If the resident has persistent pain and the cause of the pain is unknown
(Behavioural changes: an increase or decrease in an existing behaviour, or a new behaviour starting; OR resident reports pain of unknown origin)
(Figures 2-5)

Registered nurse or delegate:

- direct the care staff to complete a pain assessment tool appropriate for the resident, and document the results;
- use clinical judgement to decide whether a physical examination should commence at this point, or whether other assessments eg a Confusion Assessment Method (CAM) for delirium needs to be completed;
- if pain appears to be a problem (eg score > 3 on a 0-10 self report tool; score >5 on a Doloplus2 scale), then direct the care staff to try a non-medication intervention. Page 18 of the 'Supporting Information' provides some suggestions;
- evaluate the effectiveness of the intervention 30-45 minutes later, using the same pain assessment tool. Document on the pain management record form;
- if the pain settles, observe the resident for 48 hours. Complete the pain assessment tool once per shift for 48 hours, then revert to daily discussion and weekly review;
- if pain persists, then give a prn (as needed) analgesic per medical orders. Obtain an order for an analgesic if necessary;
- evaluate the effectiveness of the analgesic 30-45 minutes later, using the same pain assessment tool. Document on the pain management record form;
- if the pain has not settled, then review Figures 3, 4 & 5 to try to establish the cause of the pain.

Incident pain (Figure 3):

Occurs at a specific time each day, cause by an external stimulus such as wound care.

- review the pain management record form for any patterns to the pain;
- if pain has not been documented, discuss with care staff and family members who visit regularly whether they have observed signs of pain, and when. Document on the pain management record form;
- if a specific incident is identified, discuss with the person responsible, general practitioner and care staff. Analgesia should be given one hour before the incident. A trade-off between complete pain relief that causes sedation, and some pain but less sedation, may be required;
- direct the care staff to complete a pain assessment tool appropriate for the resident;
- give the analgesia as ordered;
- evaluate the effectiveness of the analgesic 30-45 minutes later, using the same pain assessment tool. Document on the pain management record form;
- If the resident appears comfortable, and the pain has settled, then continue the analgesic regime until the precipitating cause of the incident pain no longer occurs;

- If the resident IS NOT comfortable (ask him/her; check his/her behaviour):
- Contact the general practitioner to titrate the analgesic dose / type;
- Give the analgesic as ordered one hour before the precipitating incident**;**
- Evaluate the effectiveness of the analgesic using the same pain assessment tool, and document the results;
- Continue titration until pain relief is obtained during the procedure; or the resident / person responsible agrees that there needs to be a trade-off between complete pain relief versus side effects such as excessive sedation;
- Continue to give analgesia until the precipitating cause of the incident pain no longer occurs.

If incident pain does not appear to be the cause of the pain, assess further.

Chronic pain (Figure 4)

Chronic pain is prolonged pain, usually lasting more than three to six months, associated with a chronic condition such as arthritis or diabetic neuropathy. Residents with chronic pain will not display autonomic signs, for example raised pulse rate, sweating. The pain may be difficult to localise, that is, the resident won't be able to tell you where the pain is if he/she can communicate verbally, but tenderness to touch may indicate that there is a painful site. Behavioural reactions may be absent, so no evidence of pain may be seen until personal care or other movement causes a reaction like a grimace or groan.

Registered nurse or delegate:

- review the Pain Management Record Form and the resident's notes. Has the resident been newly diagnosed with one of the factors or conditions associated with pain? Is there an increase in symptoms from a chronic condition?
- discuss with the nurses and care staff, and family members, whether they have noticed any possible pain-related behaviour while personal care or other activities requiring movement are undertaken?
- complete an appropriate pain assessment tool as soon as the pain is noticed and document on the Pain Management Record Form;
- complete a brief physical assessment on the resident, including moving the limbs and taking the resident for a short walk if possible. Observe closely for signs of discomfort. Record observations on the pain management record form.

If the physical assessment indicates that chronic pain is present:

- give an analgesic as ordered, either a prn dose or breakthrough dose;
- if the resident is not receiving regular analgesia, contact the general practitioner to discuss a trial dose of regular analgesic;
- evaluate the effectiveness of the analgesic 30-45 minutes later, using the same pain assessment tool, and document the results;

- if the resident is comfortable after the analgesic, monitor for 48 hours by completing the pain assessment tool once per shift, then revert to daily discussion and weekly review;
- if the pain persists after the first dose of analgesic, give up to a total of 3 breakthrough doses of analgesic at one hour intervals, or as ordered. Evaluate the effectiveness of each dose of analgesic 30-45 minutes after the dose, using the same pain assessment tool. Document on the pain management record form;
- inform the care staff of any side effects that may occur, and direct the care staff to notify you if there are signs of side effects from the medication;
- direct the care staff to continue completing the same pain assessment tool once pet shift until the resident's pain has been stable for 48 hours, then revert to daily discussion and signing the 'Weekly Outcome Review' form.

If no specific cause of chronic pain can be found, assess for acute pain. Follow Figure 5.

If the pain is not settled within 24 hours, refer to the general practitioner for advice. The dose of analgesic may need to be changed, the type of analgesic may need to be changed, or a co-analgesic may need to be added.

Acute pain (Figure 5)

Acute pain usually starts suddenly, may be severe, and is of a brief duration. Autonomic signs are present, such as sweating, tachycardia, and nausea. Behavioural signs are also present, for example grimacing, rubbing the affected area, or resting the affected area.

Common reasons for exacerbations of acute pain include infections, fractures and trauma, cancer, and discomfort from constipation, bladder distension, and pressure ulcers.

NB that residents with known chronic pain can also have acute pain ('acute on chronic pain'). In this instance, the pain management record form will need to show the different sites of pain.

Assess for delirium: use the Confusion Assessment Method (CAM) tool: refer to the agitation framework if necessary.

Registered nurse or delegate:

- record the resident's vital signs: temperature, pulse, blood pressure, respirations, or direct the care staff to do so, and compare to baseline measurements;
- observe the resident for autonomic signs indicating acute pain;
- observe the resident and discuss with the care staff regarding behavioural signs of pain;
- direct the care staff member to complete a pain assessment tool before and 30-45 minutes after any analgesia or other intervention given;
- if the cause of the pain is not known, commence a systematic review of the following common causes:

- urinary tract infection**.** Is the urine smelly and cloudy? Undertake a urinalysis if possible, and observe whether nitrates and white blood cells are present. If an infection is present, or suspected, contact the general practitioner. Give an analgesic, evaluate it's effectiveness using the same pain assessment tool, document the results. If a urinary tract infection is NOT present, then consider:

- constipation. Review the bowel chart; observe the abdomen for distension, palpate if necessary. (Follow the bowel management framework for when constipation is suspected). The resident may be more aggressive or confused than usual: discuss with the care staff. If constipation is present, give laxatives as appropriate, contact the general practitioner if necessary. Give an analgesic if the resident does not settle after having his/her bowels open, or if treatment of the constipation is not immediately successful. Evaluate the effectiveness of the analgesic using the same pain assessment tool, document the results. If constipation is NOT present, then consider:

- chest infection. Are the resident's respirations increased? Is the resident febrile, lethargic, coughing, more confused than usual? Consider silent aspiration as a possible cause (see the weight loss framework for further information). If an infection is present, or suspected, contact the general practitioner. Give an analgesic, evaluate it's effectiveness using the same pain assessment tool, document the results. If a chest infection is NOT present, then consider:

- urinary retention. Review the resident for bladder distension. Use a bladder scan if available, or palpate the bladder. If urinary retention is present, or suspected, contact the general practitioner for advice. Give an analgesic, evaluate its effectiveness using the same pain assessment tool, document the results. If urinary retention is NOT present, then consider:

- pressure ulcers. Review the resident for pressure ulcers. Check all sites including sacrum, hips, heels, elbows etc. If pressure ulcers are present, treat them according to the facility protocol, or the general practitioner's instructions. Give an analgesic, evaluate it's effectiveness using the same pain assessment tool, document the results. If urinary retention is NOT present, then consider:

- injury. Review the resident, and discuss with care staff, family members, and other residents in the vicinity if they are able to respond. Has the resident had an injurious fall or sustained trauma from another cause that is causing pain. Assess the resident, including taking him/her for a short walk if possible to assess mobility. Contact the general practitioner if there is an injury to obtain medical advice. Give an analgesic unless advised not to, and arrange for the injury to be treated. Evaluate the effectiveness using the same pain assessment tool, document the results. If an injury is NOT present, then consider:

- other signs of illness that may be causing pain. If in the registered nurse's (or delegate) opinion the resident remains in pain from no known cause, then contact the general practitioner. Assessment and possible treatment will depend on the goals of care for the resident. Obtain an order for analgesia unless contraindicated, so the resident is comfortable while further assessment is undertaken. If no further assessment will be done due to the goal of care, then ensure that the resident is given sufficient analgesia to alleviate the pain and suffering he/she is experiencing.

NB if pain persists for 24 hours, despite the resident receiving analgesia and treatment for the acute condition, contact the general practitioner. The dose of analgesic may need to be changed, the type of analgesic may need to be changed, or a co-analgesic may need to be added;

- direct the care staff to continue completing the same pain assessment tool until the resident's pain has been stable for 48 hours, then revert to daily discussion and signing the 'Weekly Outcome Review' form.

Care staff:

- be pain vigilant: observe the resident closely when undertaking personal care and interacting with the resident;
- report signs of pain to the registered nurse (RN) or nurse in charge. Use the NOPPAIN tool if your facility endorses its use;
- complete a pain assessment tool when pain is observed, or when the RN directs you to;
- complete other observations and assessment tools as directed by the RN or nurse in charge;
- report any side effects of medication, as directed by the RN or nurse in charge;
- participate in discussions about residents' pain at handovers and meetings.
- report any side effects of medication, as directed by the RN or nurse in charge;
- participate in discussions about residents' pain at handovers and meetings.

If the resident is receiving end of life (terminal) care:

- assess the resident's level of consciousness and ability to swallow at least daily before offering food & fluids. If the resident is unable to swallow, offer appropriate mouth care only. Continue to give analgesia as ordered even if the resident appears comatose.

DOCUMENT the reasons for any decision to limit further assessments in the resident's notes. Make sure the care plan reflects the goals of care.

Procedures

1. Physical examination

Procedure 1: Physical examination	Rationale
Undertake a physical assessment of the resident.	Pain management is enhanced by a comprehensive assessment of the resident's pain. Guideline 18 (enhanced version): '*Guidelines for a Palliative Approach in Residential Aged Care*'.[5, 6]
Wash your hands.	Hand washing is the single most effective measure to decrease the transmission of micro-organisms from person to person.
Ask the resident if you may undertake an assessment for possible pain. Speak quietly and calmly. If the resident refuses, do not proceed. Try again at another time.	To obtain consent from the resident
Ask a colleague or close family member to assist with the examination. If the resident can communicate, obtain their consent for the other person's presence.	A second person is required to observe for behavioural reactions during the examination (eg the resident grimacing); consent is required from the resident.
Ask the resident "are you sore anywhere?" or "are you aching anywhere?" or "where are you hurting?" or a similar question and wait at least 30 seconds for a response.	Self-report is the gold standard for pain reporting. A resident with dementia needs longer to respond to questions than a cognitively intact person.
If the resident is able to respond, record all sites of pain on the body chart. Label each site differently eg A, B, C, D. If the resident is unable to localise the painful sites, shade large areas that are reported as being painful eg hands, arms.	Pain may occur at different sites in the body; and be of different types. This information is required to plan adequate pain management strategies.
If the resident is unable to respond to questions about their pain, commence a full physical examination. Observe the resident closely throughout the examination.	Pain may occur at different sites in the body; and be of different types. This information is required to plan adequate pain management strategies.
With the resident lying supine in bed, commence the physical assessment. Firstly, visually inspect the face and mouth. Look for swelling, redness or obvious deformity of the face; and redness, swelling, ulcers, candida infections, abscesses or dental problems in the mouth.	To assess the resident's face and mouth for sites of pain.
Visually inspect both arms. Look for redness, swelling, or obvious	To assess both the resident's hands and arms for sites of pain.

Procedure 1: Physical examination	Rationale
deformity eg caused by contractures, arthritis. Look closely at the fingers for signs of arthritis that may indicate painful areas. Then assess for pain on movement of the arms. Gently raise one arm, supporting the elbow and wrist as you do so. Straighten the arm from the elbow while maintaining the support, using a slow, gentle movement. Watch the resident's face closely for signs of grimacing, or audible sounds of pain such as moaning. Observe for resistiveness, guarding or muscle tension as you move the arm. Lower the arm, and then try to abduct it (with the resident's arm straight, and supported at the elbow and wrist, move the arm straight out from the body, horizontal to the bed). Repeat on the other hand and arm.	
Repeat the process with both legs. Firstly visually inspect both legs and feet, looking for swelling, redness or deformities. Then assess the range of motion in the legs and hip, by moving the legs one at a time, slowly and gently. Try to lift the leg off the bed, placing one of your hands under the knee, the other hand under the heel to provide support. Try to straighten the leg from the knee. Gently and slowly, with knee and heel still supported, try to abduct the leg (move it out from the midline) to assess for hip pain. Moving the leg 20-30 degrees from the midline is frequently enough to produce a response if there is pain. Use extreme caution on any resident that is known to have a hip prosthesis, as moving the leg too far from the midline may cause displacement of the prosthesis. Repeat on the other leg, again observing the resident closely for signs of discomfort.	To assess both the resident's legs and feet for sites of pain.
With the resident still lying supine in bed, stand beside him/her facing the head of the bed. Place one hand on each side of the resident's body on the hip and gently "rock" the resident's hip area side to side with your hands. Observe the resident closely for signs of discomfort.	To assess the resident further for hip pain.
Gently palpate the abdomen while the resident remains in a supine position. Check for abdominal distension, bladder distension, and presence of any masses. Observe the resident's face for signs of discomfort while attending this examination.	To assess the resident's abdominal area for sites of pain.
Turn the resident onto his/her side.	Positions the resident for assessment of pain in the spine, and

Procedure 1: Physical examination	Rationale
	shoulder area.
Place your thumbs under the edge of the scapula (shoulder blade) and gently push upwards. Have a colleague or family member standing in an area where the resident's face can be seen to check for signs of pain such as wincing or grimacing as the shoulder moves.	To assess shoulder pain.
Assess the resident's back and spine. Again, visually inspect the area for signs of swelling, redness or deformity. Check the sacral area for signs of pressure ulcer formation. Physically palpate the whole length of the spine. Make a fist of one of your hands, and using the knuckles and middle phalanges gently place your fist beside the spine and gently rock your fist from side to side, feeling for swelling or changes. Move your fist to the parallel place on the other side of the spine, and repeat the rocking motion with your fist, again using the knuckles and middle phalanges. This is a gentle motion, and does not require a great deal of pressure from the practitioner. Continue this process on both sides of the spine right down the length of the spine. Again have a colleague or family member standing where they can see the resident's face to observe for signs of discomfort.	To assess for painful sites in the back and spine.
Gently palpate the back of the skull and neck area.	To assess for painful sites in the neck and skull.
If you suspect that constipation is causing pain or discomfort, consider undertaking a digital rectal examination before turning the resident back onto his/her back. Refer to the bowel management framework for further information. If in any doubt, do not proceed with the digital rectal examination at this point. Follow your facility's procedure.	Constipation is a source of distress and discomfort to residents. People with dementia are more likely to be constipated than other residents. Even a resident who has had a bowel movement within the past 3 days may be constipated.
Place the resident back into a comfortable position.	The short physical examination is completed.
Wash your hands.	Decrease the transmission of microorganisms from person to person.
Document your findings on the Comprehensive Pain Assessment form.	This information is required to plan adequate pain management strategies.

2. Trial of self-report pain assessment tools

Procedure 2: Trial of self- report pain assessment tools [7, 8]	**Rationale**
Nurse or care worker to assess the resident's ability to comprehend a self-report pain assessment tool to report the intensity of their pain.	Self-report is the most accurate method of establishing the presence of pain, and the only method of establishing the intensity of pain. A valid pain assessment tool used regularly will provide evidence of the resident's pain experience and the effectiveness of pain management interventions
Undertake this task in the morning.	Resident is likely to be more alert in the morning.
Explain to the resident that you are going to ask him/her to tell you about any pain they may have. "I am going to show you a tool that some of the other residents use to help us understand their pain. You must tell us if you have pain, or are aching or hurting anywhere". Gain his/her consent. Make sure the resident is in a quiet area, free of other distractions.	To orientate resident and gain his/her consent to proceed.
If resident refuses or resists, try again later.	Resident may be more settled on another occasion.
If resident is non-responsive or unable to comprehend that you will be assessing him/her, record on the Comprehensive Pain Assessment form and in the clinical notes.	Resident will require assessment with a behavioural observational pain assessment tool such as the Doloplus-2.
Once consent is obtained, prepare the resident for the first trial. Ensure the resident has his or her spectacles on, has good light available and has a hearing aid fitted if available.	Compensates for sensory deficits that may compound comprehension difficulties.
Trial the tools one at a time, with a break in between each trial. If a resident is able to comprehend and complete the pain thermometer, there is no need to trial the other tools, unless the resident's level of comprehension changes at a later time. Explain the tool slowly and clearly to the resident. Reassure the	Gives the resident the opportunity to self-report his/her own pain. Establishes which tool will be used to provide evidence of the resident's pain experience and the effectiveness of pain management interventions.

Procedure 2: Trial of self- report pain assessment tools [7, 8]	**Rationale**
resident, and allow him or her a few minutes to respond to each question. Repeat the explanation if necessary. Redirect the resident if his/her attention wanders from the task, and allow a number of attempts at the tool before deciding to either trial another tool, or use a behavioural observation tool.[9] If a resident is unable to comprehend and respond to a tool within 10 minutes, abandon that trial, and leave the resident to relax. Trial the other tools on another occasion. Trial each of the three self-report tools before deciding to use a behavioural observation tool. Record the outcome of each trial (successfully able to self-report their own pain; or unable to report their own pain) on the Comprehensive Pain Assessment Form.	
The Pain Thermometer: Show the resident the thermometer. Tell the resident: "This is a thermometer for measuring pain. The bottom of the thermometer shows that there is no pain, the top shows that the pain is as bad as it could be. The middle of the thermometer shows moderate pain." Tell the resident that if he or she has pain they will be able to point to how bad the pain is on the thermometer. Ask the resident if he or she has pain now eg "Are you hurting anywhere now?" Wait at least 30 seconds for a response. If the resident responds that he or she has pain now, ask him or her to point to the place on the thermometer that matches their pain level. Record the result, give an analgesic if necessary. Pain over the level of 3 can affect functioning [8]. If the resident was unable to comprehend this scale, trial the VDS.	This tool is known to be useful with some older people with dementia.
The Verbal Descriptor Scale (VDS): As above, show the scale to the resident, and ask him or her to point to the words that best describe the pain/hurt/ache etc that he or she is feeling now. Record the response; give an analgesic if the resident has pain that requires intervention. If the	This tool is known to be useful with some older people with dementia.

Procedure 2: Trial of self- report pain assessment tools [7, 8]	**Rationale**
resident was unable to comprehend this scale, trial the Faces Pain Scale.	
Faces Pain Scale: As above, show the scale to the resident, and say "these faces show how much pain someone can feel" or " ... how much something can hurt". Point to the left-most face and say " this face shows no pain"; then point to each face from left to right and say "the faces show more and more pain up to this one" and point to the right-most face and say "it shows very much pain". Ask the resident if he or she has pain now, if the answer is yes, ask him or her to point to the face that shows how much they hurt (or how much pain they have). Give the resident a few minutes to complete, re-explain if necessary. Score the response. Record the response, give an analgesic if indicated.	This tool is known to be useful with some older people with dementia.
If the resident was unable to comprehend and complete any of the three self-report scales, record this on the Comprehensive Pain Assessment Form and in the resident's clinical notes.	Resident will need to have a behavioural observation scale used for pain eg Doloplus-2.
Make sure the resident is comfortable. Reassure if necessary.	Completes the assessment.

3. Trial of behavioural observation pain assessment tools

Procedure 3: Trial of behavioural observational pain assessment tools	**Rationale**
Doloplus-2: It is recommended that the Doloplus-2 is practiced by the nurse a few times before it is required for pain observation in a resident. Use the definitions listed and the instructions on the tool. **A score of above 5 indicates that pain is present.** Record the response, give an analgesic if indicated.	This tool has been identified in a recent systematic review as being one of the superior tools for pain observation in older people unable to self-report pain.
NOPPAIN: The NOPPAIN is designed to be used by care staff who have provided personal care for 5 minutes or longer. Follow the directions on the form. Hand the completed form to the nurse in charge for further assessment of the resident. If pain behaviours are exhibited that are more subtle than shown on the NOPPAIN, complete the bottom section of the 'Pain Management Record' form before referring to the nurse in charge.	Pain assessment is the responsibility of the whole care team. The regular care workers are often in the best position to report changed behaviour in a person with dementia unable to self-report pain.

4. Application of a transdermal patch

Procedure 4: Application of a transdermal patch	**Rationale**
Refer to local facility policies in conjunction with this procedure	
Obtain a medication order from a medical practitioner.	
Verify the correctness of the order; check the resident for known drug allergies.	
Decide on the site of application of the patch. This area should be normal (unbroken) skin on the chest, back, upper arm, or side above the waist, in an area that is flat and hairless. If the area is hairy, clip the hair close to the skin but do not shave the hair off. Avoid areas that are affected by lymphoedema; areas that move a lot; or areas that have had a skin patch recently applied to them. For cognitively impaired residents, placing the patch on the back may be the best area, to stop the resident removing the patch and placing it into his or her mouth.	Absorption rate may be affected if skin integrity is poor; shaving may disrupt the top fatty layer of skin and increase the rate of absorption.
If the skin needs washing use cold water and pat dry. Do not use talcum powder, soap, lotions or oils.	Absorption rate may be affected.
Tear open the pouch containing the medicated skin patch. Remove the skin patch from the pouch and peel off the protective liner from the back of the patch exposing the adhesive (sticky) surface. Try not to touch the sticky side.	
Immediately press the adhesive side of the patch onto the skin with the palm of your hand.	
Press the patch firmly, for at least 30 seconds. Be sure that the patch sticks well to the skin, especially around the edges.	Failure to press the patch on firmly for at least 30 seconds is the most frequent cause of patch failure.
If the patch does not stick well or comes loose after it is applied, tape the edges down to the skin with first aid tape. Check for allergies before applying any tape to the resident's skin. Do not use Opsite	Opsite or similar products used over a patch may cause faster delivery of the medication and possible overdose. A hot water bottle or other direct heat may

Procedure 4: Application of a transdermal patch	**Rationale**
over the patch. Do not use a hot water bottle on the patch site.	increase the absorption rate of the medication.
When finished applying the patch, wash your hands promptly with only clear water.	Using soap, alcohol, or other cleansers to remove any medication delivered via a patch may increase the amount of medication that goes through the skin.
Apply each new patch to a different skin area. Remove the old patch before applying another one.	Avoids irritation to the skin.
Fold used patches in half with the sticky sides together and dispose of them so they are no longer retrievable.	Used patches may still contain some medication and may be dangerous to children, pets, or adults who have not been prescribed them.
If a patch comes off the person for whom it was prescribed and sticks to the skin of another person, take the patch off that person right away, wash the area with water only, and seek immediate medical advice. This is especially important for fentanyl patches.	Accidental exposure to medication delivered through a transdermal patch may cause serious harm.

5. General principles for insertion of an indwelling subcutaneous cannula[10]

NB: Using a device such as the Saf-T-Intima cannula for subcutaneous injection improves safety for the nurse administering the medication, and improves comfort for the resident requiring subcutaneous administration of medication.

Your usual medical supplies company may stock Saf-T-Intima cannulae if you need to order a supply. If not, the following company has confirmed they are able to supply (as at the time of writing):
EBOS Group Pty Ltd (Richard Thomson)
PO Box 100
Kingsgrove NSW 2208
Ph: 9502 8400
Fax: 1800 810 257
Email: ebos@ebosgroup.com.au

Procedure 5: General principles for insertion of an indwelling subcutaneous cannula[10]	**Rationale**
Refer to local facility policies in conjunction with this procedure.	
Remove hair at the insertion site (prior to antiseptic application), using clippers (not shaved).	Improves the adherence of the dressing.
Wash the skin if necessary.	
Allow the alcohol to air dry completely before inserting the cannula; do not wipe or blot.	
Wash your hands and forearms for sixty seconds (clinical hand wash) prior to insertion of the device.	Decrease the transmission of microorganisms from person to person.
Prepare the skin using an alcohol swab. Rub the swab vigorously over an area of skin approximately 15cm in diameter, in a circular motion beginning in the centre of the proposed site and moving outward, for at least 30 seconds.	Provides thorough decontamination and reduces the risk of introducing infection to an indwelling cannula site. Allows the alcohol to work.
Do not palpate the insertion site after the application of the alcohol swab, unless aseptic technique is maintained.	Reduces the risk of introducing infection to an indwelling cannula site
Use an aseptic technique to introduce the cannula.	

Procedure 5: General principles for insertion of an indwelling subcutaneous cannula[10]	**Rationale**
Cover the inserted cannula with a sterile, transparent, semi-permeable, self-adhesive, polyurethane dressing.	Reduces the risk of infection; secures the cannula.
Write the date and time the cannula was inserted onto the dressing	Easy to calculate when a change in site is required.
Write the name of the drug to be administered onto the dressing	It is preferable to only administer one drug per cannula site, especially dexamethasone.
Prime the line with the drug to be used.	Expels air from the line. Reduces irritation and redness at the site if the prescribed drug is used rather than flushing with sterile water. Ensures the resident will receive a full dose of the drug.
Check the insertion site each shift. Resite if: • Evidence of inflammation, infection or bleeding; AND • Every seven days.	

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COMPREHENSIVE PAIN ASSESSMENT

Resident Name: .....Room / Bed No: .....

Instructions: Complete all sections of this assessment form on admission, as part of an ACFI review, and whenever there is a major change in the resident's medical condition. If pain is present or suspected assess the resident's pain for seven days using an appropriate pain assessment tool. Develop a pain management plan if pain is present.

HISTORY OF FACTORS AND CONDITIONS ASSOCIATED WITH PAIN **Goal**: to identify and document details of factors and conditions that may be associated with pain (tick if present).			
CONDITION		**CONDITION**	✔
Degenerative joint disease ie osteoarthritis		Pressure and other skin ulcers	
Gout or similar conditions		Post-stroke pain	
Chronic leg cramps		Angina	
Pain from oral or dental conditions (eg toothache, mouth ulcers)		Immobility, contractures	
Amputations (stump pain, phantom limb pain)		Fibromyalgia (syndrome of widespread pain, tenderness with moderate to severe fatigue)	
Mood disorders (eg depression)		Constipation	
Low back disorders such as vertebral compression fractures, facet arthropathies (arthritis of the facet joints between vertebrae), spinal canal stenosis		Pain due to damaged nerves eg diabetic neuropathy, postherpetic neuralgia, carpal tunnel syndrome, trigeminal or occipital neuralgia	
Peripheral vascular disease (rest pain, claudication)		Rheumatoid arthritis, other inflammatory arthritic conditions	
Cancer (list all sites)		Respiratory conditions (eg pleurisy, excessive use of the respiratory muscles due to virus)	
		Headaches (document frequency)	
Other (please list)			

TRIAL OF PAIN ASSESSMENT TOOLS. **Goal:** to ascertain whether the resident is able to comprehend a self-rating scale for pain.			
Tool	**Date**	**Able to complete? (circle one)**	**Comments**
Verbal Descriptor Scale (VDS) (Pain thermometer)		Yes / No	
VDS horizontal version		Yes / No	
Faces Pain Scale		Yes / No	
Other (state which tool)		Yes / No	
If resident unable to comprehend any of these tools, use a behavioural observation rating tool such as the DOLOPLUS2. NB. The intensity of pain cannot be assessed by observational tools.			

COMPREHENSIVE PAIN ASSESSMENT (cont)

PHYSICAL EXAMINATION OF THE RESIDENT AND PAIN HISTORY

Goal: to assess and document all sites of pain experienced by the resident, by undertaking a physical examination of the resident.

IF PAIN IS PRESENT:

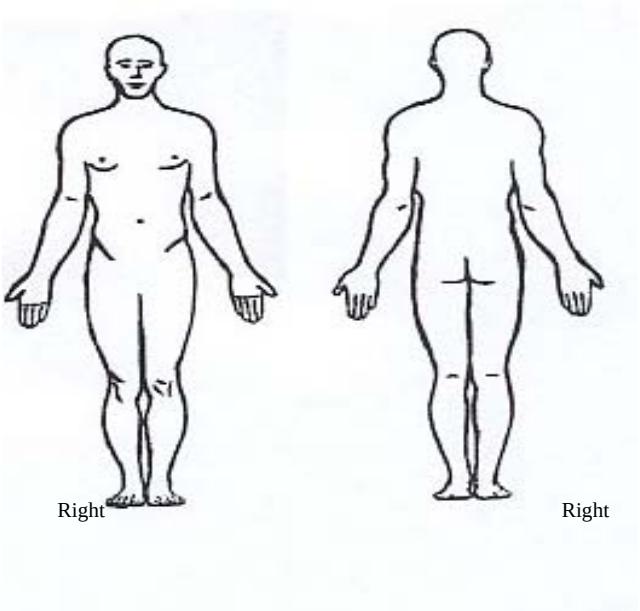
Location of pain: Indicate on the body chart all sites of pain. If resident is able to respond verbally, ask him/her to indicate areas that hurt the most.
Number each site eg A, B, C etc.
Shade large areas eg contractures on limbs.

Resident description of the pain: eg sharp, burning, throbbing, aching etc. Leave blank if the resident is unable to respond.
Record description for each site.

……..……

……..…

…….



Does the pain interfere with the resident's: (please)	**Yes**	**No**	**Some-times**	**N/A**
General activity				
Mood				
Walking ability				
Relations with others				
Sleep				
Enjoyment of life				
Is the pain intermittent, and only occurring at certain times of the day? Please state when the pain is noted:				
Does anything aggravate the pain? Please state what aggravates the pain:				
Does anything relieve the pain? Please state what relieves the pain:				
Is the resident satisfied with their current pain management?:				
Are the family members satisfied with the current pain management strategies?:				

SIGN/DATE WHEN ELEMENTS OF COMPREHENSIVE ASSESSMENT ARE COMPLETED		
	Sign when completed	**Date**
1. History of factors and conditions associated with pain completed.		
2. Physical examination of the resident completed.		
3. Trial of pain assessment tools completed.		
4. The resident has been questioned to see whether he/she is satisfied with the current pain management.		
5. The family members have been questioned to see whether they are satisfied with the resident's current pain management.		
6. Seven-day assessment of pain using appropriate tool completed.		
7. The general practitioner has reviewed the results.		

PAIN MANAGEMENT RECORD

Resident Name: ..... **Room / Bed No: .....**

Goal: to review pain, intervene to alleviate the pain, and evaluate the effectiveness of the intervention. **Instructions:** Continue until the pain has been settled for 48 hours.

Pain assessment tool to be used .....

INTERVENTION CODES

Analgesia = A	**Distraction = D**	**Massage = M**	**Reposition = R**
Communicate & Reassure = C	**Multisensory Room = S**	**Other = O (State what)**	

	Review Pain		**Treat Pain**	**Did the treatment work? Evaluate 30-45 minutes later**		
Date	**Time**	**Tool Score**	**Intervention (Use code)**	**Time Evaluated**	**Tool Score on Evaluation**	**Nurse Initial**

OBSERVATIONS BY REGULAR CARE WORKERS

Date	**Time**	**NOPPAIN completed? (Tick if yes)**	**Comments**

PAIN MANAGEMENT RECORD (cont)

INTERVENTION CODES

Analgesia = A	**Distraction = D**	**Massage = M**	**Reposition = R**
Communicate & Reassure = C	**Multisensory Room = S**	**Other = O (State what)**	

	Review Pain		**Treat Pain**	**Did the treatment work? Evaluate 30-45 minutes later**		
Date	**Time**	**Tool Score**	**Intervention (Use code)**	**Time Evaluated**	**Tool Score on Evaluation**	**Nurse Initial**

OBSERVATIONS BY REGULAR CARE WORKERS

Date	**Time**	**NOPPAIN completed? (Tick if yes)**	**Comments**

WEEKLY OUTCOMES REVIEW: PAIN MANAGEMENT
RESIDENT WITH ADVANCED DEMENTIA

Resident Name: ....Room / Bed No: ....

Goal: to continuously monitor the resident for possible pain.
Instructions: Discuss with the resident, or if unable to respond, with members of the care team and the family members, the resident's level of comfort and the acceptability of current pain management strategies. Complete the outcomes once each week.

The goal of pain management for this resident is ....

Has the goal of pain management been met for this resident? Date, circle whether the outcome has been met, not met, or is not applicable (N/A). RN initial entry. Any outcomes 'not met' or N/A require documentation in the resident's progress notes.

	Outcome 1		**Outcome 2**		**Outcome 3**		**Outcome 4**	
	The resident is able to verbalise satisfaction with current pain management		The family members are able to verbalise satisfaction with the resident's current pain management.		Family members can describe the goal of pain management and strategies used for the resident.		The multidisciplinary care team are able to verbalise satisfaction with the resident's current pain management	
Date		**RN Initial**		**RN Initial**		**RN Initial**		**RN Initial**
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	

Weekly Outcomes Review (cont)

The goal of pain management for this resident is ....

Has the goal of pain management been met for this resident? Date, circle whether the outcome has been met, not met, or is not applicable (N/A). RN initial entry. Any outcomes 'not met' or N/A require documentation in the resident's progress notes.

	Outcome 1		**Outcome 2**		**Outcome 3**		**Outcome 4**	
	The resident is able to verbalise satisfaction with current pain management		The family members are able to verbalise satisfaction with the resident's current pain management.		Family members can describe the goal of pain management and strategies used for the resident.		The multidisciplinary care team are able to verbalise satisfaction with the resident's current pain management	
Date		**RN Initial**		**RN Initial**		**RN Initial**		**RN Initial**
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	
	Met Not Met N/A		Met Not Met N/A		Met Not Met N/A		Met Not Met N/A	

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Mrs Cheryl Van Den Nieuwenhuizen	Director of Nursing, Chesalon residential Aged Care Facility, Richmond
Ms Carolyn Fularon	Director of Nursing, Minchinbury Manor residential Aged Care Facility
Ms Sue Briggs	Clinical Nurse Consultant Quality Improvement, Primary Care & Community Health Network, SWAHS
Ms Carol Denne	Nursing Education Coordinator, Primary Care & Community Health Network, SWAHS