Pain Assessment and Management Record

Name: ____ **Physician:** ___________________

Diagnosis: _______________________________________ **Allergies:** _______________________

ESAS Pain Score: __________ **Date:** ______________ **PPS Score:** __________ **Date:** ____________

Behavioural Pain Indicators: 1. _______________________ **2.** ____________________________

(Describe clearly e.g. resisting care/pushing staff away , pacing the halls, moaning, rubbing the particular area involved)

Pain: **Collect as mush data as possible directly from the resident. If necessary, collect data from family and staff.**

Locations **Where is the pain? Does it radiate? (see ESAS diagram)**	***Quality*** **What does it feel like? Descriptor words used**	***Severity*** **How bad is it? Rate on a 0-10 scale.**	***Timing*** **Is the pain constant or intermittent?**	***Duration*** **When did it start? How long have you had the pain?**	***Provokes*** **What makes it worse?**	***Palliates*** **What makes it better?**	***ADL's / IADL's*** **How is it affecting your life? i.e.: sleep, appetite, activities, mobility, emotions, sexuality.**
		At best: **At worst:**					
		At best: **At worst:**					
		At best: **At worst:**					

Associated Symptoms: ☐ nausea ☐ vomiting ☐ anorexia ☐ constipation ☐ other: _______________

Current Medications/Herbal Remedies for Pain:

Drug, Dose & Frequency	Route	Total in Past 24 Hours	Side effects experienced?	Efficacy from person's point of view

Non drug interventions tried: ________________________ **Outcome:** _________________________

Analgesics tried in past and outcomes:

Medication	Outcome	Medication	Outcome

Comfort Goal: Desired pain score: _______ Desired Function: ________________________________

Team Concerns: (include identified fears, barriers, myths) ____________________________________

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Physical exam: ____

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Questions for the physician / clinical nurse specialist: ______________________________

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Interviewing nurse signature:________________________________ **Date:**____________

Pain Classification: (to be determined in consultation with the physician / clinical nurse specialist)

☐ **Visceral – poorly localized, can be referred to another site, often gradual onset, deep aching, crampy, pressure (internal organs)**
☐ **Somatic - well localized, sharp, dull, aching, throbbing, gnawing(i.e. muscle, bone, joint)**
☐ **Incident pain –pain on movement(e.g. arthritis, bone mets)**
☐ **Breakthrough pain, occasional exacerbations of pain**
☐ **Neuropathic – burning, shooting, stabbing, deep aching, numbness and tingling, electric shock, vice like; caused by pressure, invasion or destruction of peripheral or central nervous tissues.**
☐ **Mixed – combination of visceral, somatic, and/or neuropathic (e.g. tumor invasion of pancreas, with spread to and destruction of vertebra)**
☐ **Unknown – persistent pain, cause cannot be determined by history and investigations.**

Considerations Related to Pain Management:

☐ Around the Clock (ATC): indicated for pain or discomfort experienced for 12 or more hours / 24 hours

☐ Breakthrough / PRN: indicated for occasional pain, exacerbations of pain or incident pain

☐ Adjuvant: e.g. NSAID, tricyclic, anticonvulsant, steroid: indicated for specific pain diagnoses

☐ Nausea Management: consider prophylactic intervention, consider the cause (gastric stasis, CTZ mediated) and choose appropriate medication

☐ Bowel Management: peristaltic laxative required whenever opioids are ordered, initiate at time same time as the opioid

Physician's determination of etiology of the pain:

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Initial Interventions:
Medications:

Nursing measures:

Plan for monitoring interventions:

Nurse Signature: ____________________________________**Date:** __________________

Pain Management Follow-up

Date	Review Progress made toward meeting goals Side effects, other concerns	Action Plan
Consider Palliative Pain Consultation if goals are not met.		

User Guide for Pain Assessment and Management Record

1. Complete the demographics.
2. Use the body diagram on the back of the ESAS to determine each specific location of pain. There may be several locations and each may have a different etiology.
3. Note any observed behaviours that indicate the person is having pain. Be specific in describing the behaviour. Avoid terms like aggression or agitation.
4. Assess each pain asking the questions outlined on the form.
5. Note any associated symptoms by ticking the appropriate box.
6. Document current drug interventions including herbal remedies, their effectiveness and side effects.
7. Document non drug interventions including heat, cold, acupuncture, aroma therapy, relaxation techniques etc.
8. Note analgesics previously tried and the outcome.
9. Determine the individual's comfort goal as a pain score as well as in terms of function.
10. Note any concerns including identified barriers, fears (e.g afraid that he will become addicted to medication, believes that nothing can be done and she just needs to live with the pain)
11. Do a physical exam and note any observations (e.g. pain in left shoulder when arm is raised)
12. Review the Health Record and note any pertinent information that needs to be discussed with the physician.
13. The nurse who has gathered the data signs and dates the form.
14. In consultation with the physician, the cause/etiology of the pain and the type of pain is determined. The type of pain will determine which interventions would be most appropriate.
15. Tick off the boxes related to orders indicated and ensure that each is discussed with the physician when planning interventions.
16. The nurse involved in developing the initial pain management plan documents the plan and signs and dates the form.
17. The interventions are monitored for the specified time period as indicated on the plan using the pain flow sheet
18. Nurse(s) responsible for the person reviews the progress as documented on the pain flow sheet and collaborates with the physician until pain control is achieved.