PAIN

1) All residents must be assessed for conditions/situations in which they may be at risk for pain and measures implemented for prevention. An example of this is:

   a. Resident has a Dx. of fractured hip/repair. It can be anticipated that the resident is at increased risk for pain with positioning, ADL's, therapy, etc. One way to help alleviate the risk for pain is to implement positioning devices, cushions, specialty mattress, etc. Another prevention intervention would be to consult with therapy regarding what time resident will be having therapy so pain medication can be administered prior to that time.

2) All residents must be assessed for non-pharmacological pain relief interventions. Examples of this are:

   a. Resident has complaints of leg pain when placed in bed. Resident states she has used muscle rub in the past for this and it works well. The Nurse should relay this information to the resident's PCP to obtain an order for the muscle rub vs. automatically administering pain medication.

   b. Resident states that he always has back pain when he gets up in the morning. Resident may benefit with an order for hot packs vs. automatically administering pain medication.

3) All resident must be asked if they are having pain every shift and documented per the Emar/progress notes as applicable.

4) Prior to administering prn pain medication, the Nurse must determine:

   a. **Where** the pain is (i.e. back, leg, surgical site, etc.).

   b. The **intensity** of the pain (use the Wong Baker/Non-verbal Pain Scales to determine this).

THESE LAMINATED PAIN SCALES HAVE BEEN PUT ON EVERY MEDICATION CART!

   c. The **type** of pain (i.e. sharp, dull, throbbing, etc.).

   d. **When** the pain started (i.e. after meal, after therapy, before breakfast, etc.).

e. **Aggravating** factors (i.e. sitting up, laying down, when urinating, etc.).

5) All pain must be documented thoroughly:

Inappropriate documentation: Res. c/o right hip pain.

Appropriate documentation: Res. c/o of dull ache to right hip surgical incision. Rates pain at a 4 per Wong-Baker Pain Scale.

Inappropriate documentation: Res. appears to be in pain.

Appropriate documentation: Res. assessed as having pain per Non-verbal Pain Scale. Res. has fists clenched and is moaning. Res. guarding abdominal area with arms. Res. nods when asked if having pain to abdomen.

Falls and Change of Condition Reporting

Reporting of Change in condition/falls:

1. Change in condition can be:
    a. Physical
    b. Mental
    c. Verbal
2. Falls are any involuntary change of plane to include lowering residents to the floor that would have otherwise resulted in a fall.
3. If a resident tells you about an incident or you hear or see a change in condition, tell your supervisor immediately.
4. Supervisor or appropriate personnel will …
    a. Notify the nursing supervisor or Head of House immediately.
    b. Nursing supervisor and floor nurse will assess resident together.
    c. Assess the resident to include: neurologic assessment, range of motion, pain scale appropriate to resident, full skin assessment and full vitals.
    d. Notify family:
    POA is to be notified when an incident (change in condition/fall) occurs as soon as possible. If an incident should happen in the middle of the night and there is no injury the POA can be notified in early a.m. If 3rd shift nurse is not able to reach the POA in early a.m. before clocking out, she/he is to make sure the 1st shift on coming nurse is aware that they were not able to reach the POA and for the 1st shift continues to attempt to reach the POA. If an incident occurs and there is an injury POA is to be notified at that time no matter how late it is. Staff is to try all phone numbers listed on face sheet if you cannot reach at the first number attempted. The nurse must document that she/he notified the POA or attempted to notify the POA and if more than once how many times they attempted to reach the POA.
    e. Notify Doctors, etc. if indicated
    f. Place resident on 72hr change in condition or fall assessments to include neurological checks and vitals.
    g. Document the fall or change in condition.
5. Bruises and other skin conditions are to be reported immediately, even if they appear old. The nurse is to check to see if it has been reported yet, and if not - chart it and fill out an incident report.

***NOTIFICATION CHAIN:**

1) Nurse to Unit Coordinator.
2) Unit Coordinator to HOH/ADON/DON
3) ADON/DON to Administrator

*If no Unit Coordinator on duty, HOH is to be notified by the Nurse. If no HOH, the ADON/DON on call must be notified. Any suspected abuse must be reported to the Administrator!!

This has been in-serviced in November of 2016, again in March of 2017, & again January 2018.

Heddington Oaks