Sullivan County Department of Public Health

Title: Pain Assessment **Number**: CP-13 **Page Number:** 1 of 2	Original Approval: 3/15 Reviewed/ revised: 6/19, 5/24

Statement/ Purpose:
To eliminate or reduce pain in patients receiving SCDPH home care services.

Authority:

Application:
All SCDPH CHHA staff

Terminology:

Responsible Party:
Training and Quality Improvement Coordinator

Cross-Reference:
The Outcome and Assessment Information Set (OASIS), Admission to CHHA, Care Planning- Coordination of Services

Procedure:
Patients receiving home care services will be assessed for pain at each visit. Patients and caregivers will be instructed on pain relief measures and their effectiveness will be assessed. The patient's health care provider and members of the health care team will be kept informed of patient's status.

1. At each home visit, pain will be assessed by identifying and documenting:
    a. A description of the pain using the patient's own words, or non-verbal scaling tools.
    b. Location of pain. If more than one location, document each separately.
    c. What activities increase the pain or help to decrease the pain.
    d. Severity of the pain using the pain scale- both before and after medication or treatment to improve the pain. If patient is unable to use the numeric scale- use FACES.
    e. Patient's status with the pain level, i.e., is patient able to perform normal activities, ROM etc, or is pain interfering with these activities? Document any effect the pain is having on the patient's quality of life- eating, sleeping, coping, etc.
    f. Medications the patient is taking for pain. When the last dose was and how much was taken in the last 24 hours. In addition, document any non-pharmacological measures for pain relief.
    g. Upon admission, the admitting clinician will notify the provider of the pain assessment if applicable. Document notification and orders received, if any, in a note.
    h. Clinician will notify provider if patient's pain is not significantly controlled (using the pain scale) and obtain new pain control order(s) if applicable. Notify the provider if there is an exacerbation in the

level of pain and any possible cause. Document these communications and any new order(s) received.

i. Coordinator of Services (COS) notes must include any complaints of pain and this information is shared by and with all disciplines involved in patient's care.
j. Any services in the home must report a complaint of unrelieved or new pain to the Case Manager.
k. Patients and caregivers will be taught the importance of adhering to a prescribed pain control regime, the proper use of pain medication, and other pain control measures. Patient's will be taught proper security and storage of their pain medications. All teaching is to be documented.