

Pain and Symptom Management PC.P10

Regulatory Citation(s):	42 CFR 418.52(c)(1); 418.54(c); 418.56(c)(1); 418.108; 418.108(a) Hospice Item Set section J: Pain
L-Tag(s):	512, 524, 546, 705, 706

POLICY: The IDG ensures that patients receive effective pain management and symptom control from the hospice for the terminal illness and its related conditions.

PROCEDURE:

1. The hospice nurse assesses the patient's pain and other symptoms as part of the initial assessment. Based on findings from the initial assessment, the hospice nurse ensures that the patient's immediate care and support needs are met.
2. If the patient reports or visibly demonstrates that s/he is having pain, then the nurse completes a comprehensive pain assessment that includes at least five of the following elements of pain: location, severity, duration, frequency, what relieves pain, what worsens pain and the effects on quality of life.
If the patient is unable to verbalize their pain, the nurse may:
 - a. use a caregiver report of pain
 - b. use clinical notes that identify "crying, whining, grimacing, groaning, clenching of jaw, guarding, rubbing, bracing or clutching"
 - c. The nurse should attempt to gather and document the 5 elements of pain by recognizing if the patient responds to intervention (what improves pain), if they are guarding or rubbing an area (location), severity (PAIN-AD scale) or any other non-verbal cues.
3. Whenever a patient or family reports pain, the case manager, or designee should visit the patient more frequently, up to daily visits, until the pain or symptoms are controlled to a level that the patient reports is within their self-identified threshold.
4. The patient's pain and other symptoms related to the terminal condition are thoroughly assessed during the comprehensive assessment of the patient by the RN Case Manager or designee.
5. The comprehensive assessment includes a standardized assessment tool that allows patients can rate their level of pain. Discussions with the patient regarding pain levels help to determine whether the pain-related interventions on the patient's plan of care are effective in bringing the patient's pain down to an acceptable level.

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6. Pain is re-assessed during every home visit, any time a patient states that his/her pain level has changed, and whenever pain medications or dosages are changed. This information is documented in the patient's clinical record.
7. If the patient is not receiving relief from the current pain medication or dosage, the nurse notifies and confers with the attending physician (if any) and the hospice physician and carries out the recommended action(s) as ordered by the physician.
8. Interventions to manage the patient's pain are included in the patient's plan of care.
9. Guidelines and/or protocols are developed for the assessment and management of common physical symptoms that are addressed by the IDG in the patient's plan of care, including, but not limited to:
 - a. dyspnea;
 - b. nausea and vomiting;
 - c. anorexia;
 - d. anxiety and confusion;
 - e. pressure ulcers;
 - f. constipation;
 - g. fatigue;
 - h. restlessness and agitation; and
 - i. sleep disorders.
10. Short-term inpatient care is available when a patient's pain or other symptoms cannot be effectively managed at home.

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