NURSING PROTOCOL AND PROCEDURES

Procedure: Monitoring Pain	Subject: Recognition of Pain
Performed by: RN, DSP, Caregivers	Date Written: August 2019 Prepared By: RN

General: Everyone experiences pain. However, early recognition of signs of pain can decrease the duration of discomfort for individuals and enable them to go back to their daily routine and activities. The aim is also to decrease stress, tension, and subsequently decreasing the pain.

Mary is able to indicate yes and no. If you suspect pain, ask her.

Start with Non-pharmacological Interventions:

1. Offer snack or drink
2. Offer a change of environment/activity
3. Reposition the individual
4. Determine if toileting/changing is required
5. Check comfort level (too hot/too cold)
6. Does she have her favorite pillow within reach?
7. Check her temperature
8. When was her last bowel movement?

If interventions to address the above are not successful, call the RN to complete a pain assessment.

SIGNS AND SYMPTOMS OF PAIN IN NON-VERBAL INDIVIDUALS

- Vocalizations- either onset of a new sound, or lack of sound
- Changes in appetite-refusing to eat
- Self-Injurious behavior- hitting self, biting self, banging head
- Anxiety-crying, increased breathing, trembling, sweating
- Unable to concentrate or stay on task
- Irritability/agitation
- Changes in sleep pattern
- Increased Blood Pressure and Pulse
- Nausea and vomiting
- Movement-restlessness

- Facial-change in facial expression, squinting face or eyes, frowning, mouth turned down, chin quivering as if getting ready to cry, appears sad, depressed, furrowed brow
- Muscle tension- in shoulders, face, clenched jaw
- Grinding teeth
- Guarding-unwilling to move body parts, does not want you to touch body part
- Rubbing area of pain

When Mary is experiencing pain or discomfort, she will hum, rock in her wheelchair, and grimace.

PROCEDURE:

1. Identify pain symptoms. Notify Nurse. Obtain a set of vital signs (BP, P, R, Temp, Sp02)
2. Encourage Mary to use her communication device to identify if she is experiencing pain or ask Mary so that she can answer "yes" or "no" by nodding.
3. Try non-pharmaceutical interventions listed.
4. If non-pharmaceutical interventions are not successful, administer a PRN dose of _____
   , _____mg every _____ hours for pain. If Mary is still exhibiting signs of pain in one hour after administration notify nursing so that a pain assessment can take place.
5. Report any observations such as (Mary keeps rubbing her head, Mary is groaning, Mary is crying, Mary is guarding her stomach).
6. Nurse will complete a pain assessment, call PCP, activate 911 or provide further directions for Mary's care based on physician orders.

OBSERVATIONS THAT REQUIRE PROMPT A REVIEW BY A HEALTH PROFESSIONAL

- Abdomen firm to touch and/or looks distended and bloated

- No bowel movement for 3 days
- Fever of 101 or greater
- Any redness, swelling, or injury, foul smelling wound
- A reported fall
- Recent choking episode
- Nausea and/or vomiting
- Refusing to eat or drink
- Refusing offers to toilet
- No Input/Out (Refuses drink, no wet briefs or toileting in 4 hours)
- Foul smelling urine/discolored urine/dark urine
- Change in alertness
- Seizure activity
- Changes in BP and Pulse from baseline
- Signs of Stroke (facial drooping eye or mouth turned downward, weakness on one side of body, excessive drooling or unable to control food or liquid in mouth)

Approved by/date:_____
physician

Nurse Trainer _____

Read/Trained by Staff: Date:
