Aged Care Pain Management Flowchart
NSQHS Standard 4 & 5 & ACQS Standard 2 and 3

WHAT: Identify residents with pain
e.g. medical history, pain medication, history of use of other non-pharmacological interventions, immobility, reduced function, pressure injury etc.

WHEN to complete pain assessment:
- On admission
- In the event of a significant change in a resident's condition
- any time pain is suspected
- at least every three months

Comments
Individual resident wishes and goals must be established through inclusion of the resident and their carer/representative in all aspects of the pain management process.

How:
- Complete **RC5** **on admission** followed with **RC9** (Pain assessment/ Abbey Pain Scale if pain is identified)
- *Complete* **RC10***/ Abbey Pain Scale when there is an* ***increase in already identified pain***
- For non-verbal residents who may have hearing and speech impairment or cognitive impairment, use other alternative communication methods, e.g. picture cards
- Notify treating doctor when there is new or increase in pain

Monitor
- Evaluate pain management strategies using **RC10**
- Store in front of medication file when evaluating pain.

Care Plan
- Document pain management strategies in the care plan.
- Review pain management strategies every three months, on regular use of PRN analgesia/ other interventions and on change of patient's condition.
- Consult with resident, family, doctor and other relevant health professionals about strategies

Referrals
- Refer to PT and/or OT for comfort support and exercises
- Refer to a pain specialist after reasonable trials of pharmacological and non-pharmacological therapies

Note
- For consistency in identifying and managing pain same assessment tools must be used for the individual resident.
- Abbey pain scale with descriptors is a better tool in determining level of pain as opposed to just the faces.