

# Pain Management

## Standard:

The patient experiencing pain will be appropriately assessed and interventions will be made in a timely manner to provide pain relief.

## Patient Outcome:

The patient will exhibit adequate pain management as evidenced by verbal description, pain scale and indirect assessment.

## Personnel:

1. Registered Nurse
2. Licensed Practical Nurse
3. Registered Nurse Applicants under the supervision of a Registered Nurse
4. Students under supervision of an Instructor

## Supportive Data:

1. The following pain scales may be utilized:
  - a. Critical care , ambulatory service areas, and med-surg units use a pain scale based on zero to ten:
    - 0 no pain
    - 1-2 mild
    - 3-4 discomfort
    - 5-6 moderate
    - 7-8 severe
    - 9-10 excruciating
  - b. The Birth Place uses a pain scale one to four:
    - 1 mild discomfort
    - 2 moderate
    - 3 severe
    - 4 excruciating
  - c. The Happy Face/Sad Face scale specific to unit for patients with communication/language barriers.
  - d. The Wong-Baker face scale is used for children.
  - e. The Infant Pain scale is used for infants:
    - S = Sleeping
    - 0 = No pain
    - 1 = Restless/fretful
    - 2 = Facial grimacing
    - 3 = Favors body part (knees at abdomen, pulls at body part)
    - 4 = Crying uncontrollably

## **Detailed Instructions:**

### **I. Assessment**

- A. Upon admission and on routine rounds, the nursing staff will assess the patient for pain. Location and scale are assessed if pain is present. (*Scale number or the appropriate descriptive word may be used. Example: For a medical/surgical unit, nurse may document +5 pain or “moderate” pain.*)
- B. Not all patients are able to describe pain (i.e. infants, patients unable to communicate). Pain assessment for these patients should be based upon behavior, facial expression and the appropriate pain scale applied.

### **II. Plan of Management**

- A. Pharmacological treatment of pain as ordered by the physician will be administered in dosage and time frame specified. The nurse will assess the effectiveness of the medication within thirty (30) minutes for IV medications, ninety (90) minutes for IM and PO medications. If the patient is not relieved or does not indicate either verbally or non-verbally that pain is at a tolerable level, the physician may be notified.
- B. Pain management interventions may also include, but are not limited to:
  1. Comfort measures.
  2. Visual imagery.
  3. Relaxation techniques.
  4. Diversional activities such as music therapy, videos, games.
  5. Interaction between family/friends.
  6. Discussing worries/fears.
- B. Cancer Pain Assessment and Management is initiated on patients experiencing cancer pain. Management includes but is not limited to:
  1. Analgesics
  2. Non-pharmalogical Therapy
  3. Patient/Family Teaching
  4. Cancer Pain Strategies (Palliative Therapy, Adjunctive Drugs)

### **III. Documentation:**

Assessment and appropriate interventions will be documented as follows:

#### **A. Nursing Care Record**

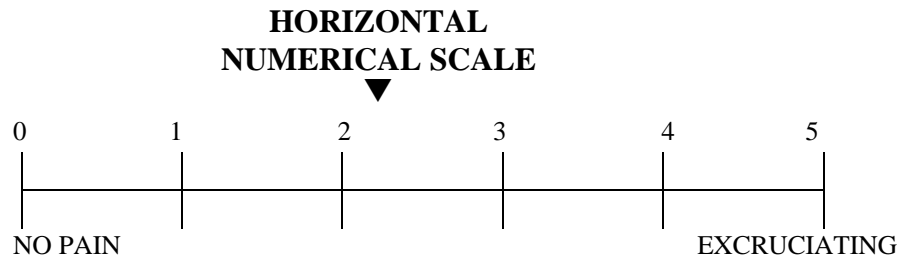
1. Verbal description by patient/significant other of the pain or *discomfort* (i.e., *c/o abdominal pain*).
2. Behaviors that exhibit pain (i.e., *thrashing in bed, moaning*).
3. Nurse’s assessment, using the pain scale and the nursing interventions.
4. Effectiveness of the interventions.

#### **B. Medication Administration Record**



## CHILD PAIN SCALE

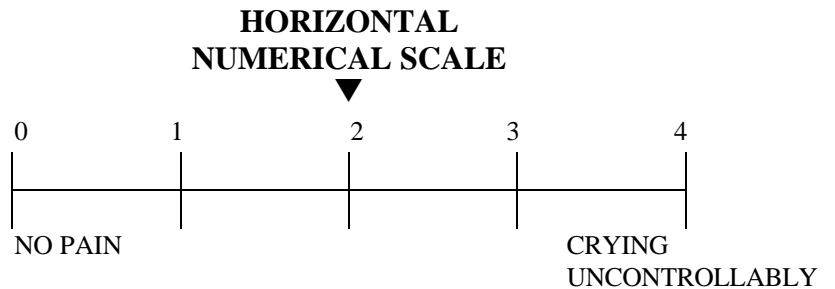
- S - sleeping
- 0 - no pain
- 1 - mild
- 2 - discomfort
- 3 - moderate
- 4 - severe
- 5 - excruciating



0                      1                      2                      3                      4                      5

## INFANT PAIN SCALE

- S - sleeping
- 0 - no evidence of pain
- 1 - restless/fretful
- 2 - facial grimacing
- 3 - favor body part
- 4 - crying uncontrollably



0                      1                      2                      3                      4