Pain Assessment and Management for patients in ER setting

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Introduction

Pain is a physiological manifestation that accompanies the individual during the birth process, over the course of growth and development, in sickness and at death. Pain is the most important and the most common subjective condition that makes individuals to seek help from health professionals. It is for this reason that pain assessment is very dependent on the nurse-patient relationship. However, nurses must also be skilled in obtaining a detailed pain history, which might involve analyzing the patient's experiences, continuous observation of physiological parameters and using pain assessment tool. (Puntillo & Wilkie, 1999). The most reliable source for data on the patient is the patient him self or herself. In emergency cases where the patient's situation is serious, the evaluation of pain become very difficult and need a skillful person and a systematic process to have accurate findings. (Pasero & McCaffery, 2000). This raises so many questions:
Are there specific standards or protocols for managing the patient's pain in ER setting?
Are there qualified nurses in the ER setting to deal with patient's pain appropriately?
Is there enough pain assessment for the patients in the Emergency setting?
Is there enough pain management for the patients in the ER Setting?

Nurses are patients' advocates and should act all times in such a manner as to promote and safeguard their interests and wellbeing (UKCC, 1998). This includes ensuring that patients have their pain managed appropriately. To assess and relieve pain effectively, nurses need to be competent in this area. The World Health Organization (WHO) states that competence requires knowledge, appropriate attitudes and observational, mechanical or intellectual skills, which together account for the ability to deliver a specified professional service (WHO, 1988).

From the observation to the staff nurses in the ER department in Jordan University Hospital and Islamic hospital, we have noticed that there are no standards or protocols for the nurses to follow in assessing and managing the pain of the patients coming to the ER department. Also, the pain assessment and management is a doctor responsibility (only) and there are no qualified nurses to take an action regarding the patient's pain. Furthermore, the assessment and management for the pain as the patient have said is not that enough.

This project will be implemented in the ER Department in Jordan University Hospital and Islamic Hospital. The purpose of this project is to create a standards and protocols for pain assessment and management in the ER Department and to change the attitude of the
nurses toward pain assessment and pain management in the ER department setting. Also, trying to implement the idea of introducing a pain management nurse specialist in the ER setting of our hospitals that will be responsible for pain assessment and management depending on his authorities and capabilities.

Literature review

Pain is a complex, multidimensional phenomenon. A patient’s pain experience is influenced and modified by a number of factors including experiential, behavioral, emotional, physical and contextual component. To manage pain appropriately, nurses need to have understanding of each of these components and nurse's education should equip them with this knowledge (Carter, 1994). Most of the nurses defined pain as an unpleasant sensation and a physical finding, and that they accepted tachycardia and an increase in arterial blood pressure as a physiological response and restlessness as a behavioral response (Aslan et al, 2003).

Inevitably, pain which is not adequately addressed may result in many complications, such as hypoxemia resulting from respiratory disorder, myocardial ischemia resulting from increased sympathetic activity, sodium and water retention, decreased gastrointestinal activity and venous stasis related to inactivity and thromboembolism. Therefore, performing pain assessment is of vital importance for vulnerable groups such as emergency department patients (Asello, 2001). The physical and psychological implications of mismanaging pain have an impact on both human and economic terms (Morton, 1998). From a human point of view the unnecessary pain endured by patients result in increased suffering and misery, and in the case of chronic pain can affect life style and personality (Beals et al., 1983).
Nurses play a key role in the assessment and management of patient’s pain. However, studies conducted in various clinical setting have consistently shown that nurses tend to underestimate patients pain and under medicate patients for their pain (Ferrel et al., 1990). Thus, while there may be situations where medical practitioners under prescribe pain relief, previous research suggest that nurses magnify the problem by continuing to administer analgesia at the lower end of the range of possible doses—even when patient’s pain is not relieved by these doses (Carr, 1990). Several studies have founds that nurses aspire to reduce patient’s pain rather than to completely relieve it (Weis et al., 1983 Fox, 1982). It has been suggested that nurses appear to associate certain types of surgical or medical conditions with certain expectation about the severity of pain and the appropriate duration of analgesic therapy with narcotics (Balfour, 1989). For example, nearly half of the nurses in one study stated that they would administer narcotic analgesics to post operative or trauma patients for a maximum of three doses (Balfour, 1989). Other studies have found that large proportion of nurses may lack a working knowledge of the proprieties and actions of narcotic analgesia have exaggerated fears of the addiction and respiratory depression and don’t understand the principle of scheduled analgesic administration (Hamilton & Edgar, 1992). Nurses education does not appear to be preparing nurses to manage pain in the clinical area. A number of studies have demonstrated that nurses continue to have educational deficit in this context. Several studies have found no changes in knowledge or behaviors following education about pain management and other have found that changes in behavior do occur (Twycross, 2002).
Despite the proliferation of research in pain management in the past 20 years, patients are still suffering unnecessary pain and this can be attributed to a number of facts. Nurses, for example, appear to feel:

1- Happier with aspects of care, which can easily quantifiable,

2- That, as pain is an expected outcome of many medical procedures, pain relief doesn’t need to be prioritized,

3- That pain management is not really their responsibility, because it is doctors who prescribe analgesic drugs (Yates et al., 1998).

Works undertaken in the past 20 years relating to pain management demonstrates that pain is not an inevitable consequence of medical interventions and can be controlled with, for example, the right drugs and better assessment so there is no reason why nurses should not be assessing and managing pain effectively (Day, 1997). It is also possible that the key to improving pain management among nurses is to improve educational input although the link between knowledge and the acquisition of skills needs considering.

Nurses may have theoretical knowledge about pain management but this does not necessarily mean that they are able to use this knowledge in practice. However, if they don’t have the theoretical knowledge which underpins the skill of pain management, they will be unlikely to be competent practically in this area (Reece and Walker, 1997).

Based on marles study, it is possible to implement pain management program (PMP) in a normal clinical setting. This study demonstrated that both nurses and doctors are positive about daily pain assessment and want to continue with it. Furthermore, the study showed that the level of nurses and physicians knowledge about pain and pain management is moderate. Educating nurses about pain and pain management proved to
be effective in increasing nursing knowledge and satisfactions about the quality of pain treatment. Based on these results, participating hospitals are advised to continue and extent the pain management program (Marlies et al., 2001). Both nurses and patients need clarification of the patient role in pain management. Addiction concerns continue to be evident and need to be addressed by educators. To understand the contribution of knowledge to pain practices more clearly, investigators should include a stratified sample related to nurse's level of education in future research (Watson et al., 2000).

Key Concepts in the Project

Kurt lewin's theory will be used to change the attitudes and behaviors of the nurses toward pain assessment management through the use of the sheet that include the standards and protocols for pain assessment and management and the use of health education program. (Appendix A & B) Also, the theory will be used to introduce pain management nurse specialist in the ER Department.

According to Kurt lewin's theory the behavior is the result of a dynamic balance of forces working in opposing directions and to conduct any change we have to go through three stages. The first stage is unfreezing stage in which a force field analysis will be done to identify the driving forces that encourage nurses to make enough pain assessment and management for the patients in ER setting and the restraining forces that restrain nurse's abilities to make enough pain assessment and management for the patients in ED setting. Also, clarifying for the new pain management specialist nurse role will be done in this stage. The second stage is moving stage in which data will be collected about the level of knowledge the nurses have and a detailed plan will be putted to change the attitude and behavior of nurses toward pain assessment and management. Also, selecting
tow or more nurses and sending them 6 month's outside to take advance courses in pain assessment and management. The third stage is refreezing stage in which stabilization and integration for the new change will be done. Also, the integration of the new role of pain management specialist nurse will be done in this stage.

Also, we will apply the concept of power. The power is defined as the ability to change the attitude and behaviors of an individual, people and group (Harrison, 1989). The type of power we are concerned is the expert power, which is gained through knowledge, skill and time. So, we will select those nurses who are expert in many clinical practices to help us in changing the attitudes of the others toward pain assessment and management.

Specialization is another concept is to be used. Specialization defined as narrow focus on part of the whole field of nursing. This is justified by:

1- The need for new specialization due to increased amount and complexity of knowledge and technology.

2- The complexity of services exceeds the prevailing knowledge and skills of general practitioners.

Plan for implementing the project

Kurt lewins theory consists of three stages:

1- Unfreezing

It is the first stage during which motivation to create change, which is changing the attitudes and behaviors of the nurses toward pain assessment and management in ER
Department setting and introducing pain management specialist nurse as a new position in ER Department.

Through this stage, information about adequate pain assessment and management, its benefits and its role in increasing patient's satisfaction will be collected. Also, the need for change will be identified by noticing the continuous suffering of the patients from inadequate pain management and by identifying the defect of current situation without the presence of pain management nurse. This could be by reviewing the problem in the literature and from ER Department records.

In addition, we have to make force field analysis, which include the driving forces that encourage moving toward the desired change and the restraining forces that restrain moving toward the desired change. The restraining forces in our project are:

1- Large proportion of nurses may lack a working knowledge of the properties and actions of narcotic analgesia and exaggerate the fears of addiction and respiratory depression.

2- The believe of nurses that pain management is not their responsibilities, because it is a doctor who prescribe analgesic drugs.

3- The believe of nurses that as pain is an expected outcome of many medical procedures, pain relief doesn't need to be prioritized.

(We will overcome these forces by establishing health education programs to improve nurse's practices in pain management and to remove the lack of knowledge and misconceptions that the nurses have)
4- Lack of pain assessment tool and a management protocol for patient coming to the ER setting. We will overcome this problem by attaching a sheet include a pain assessment tool and a standards or protocols for pain management.

5- Financial aspects through the need to send personnel outside 6 months. We will overcome this problem by convincing the administration with the financial benefits of introducing pain management nursing and by mandating the nurses to work for specific period after returning back. (The quality of care will be better by introducing this pain management specialist nurse, and this will consequently result in more satisfaction and more financial outputs for the organization).

6- Also, resistance may be faced from physicians within the ER Department. And this will be resolved by enrolling the physicians in the health education programs and telling them that the nurses who are the closest one to the patient is the best one who assessing the pain and can take the appropriate action to relief the pain. And this educational process will guarantee a qualified nurse in the field of pain assessment and management.

The driving forces in our project are:

1- The health education programs that will be conducted to provide information for the nurses about the importance of this problem and the best ways to make pain assessment and management for the patients in critical care setting.

2- The frequent supervision and rechecking about patients pain assessment and management process (this will be done by pain management nurse).

3- The most important is the staff support since many of them are complaining from tardiness of physicians to respond to pain complains by patients.
4- Another driving force will be gained from the Jordanian council of nurses, which supports the idea and promise to help in getting permission for the nurses to have their full authorities through their works.

The second stage according to Kurt lewin theory is moving, which defined as the actual changing when new responses are developed based on the collected information. A detailed plan is putted and includes the following:

1- Make a rapid assessment by asking the patients about their pain management satisfaction and review the patient’s records to see the level of satisfaction and to see the level of concern in pain management for the ER department.

2- Convincing the ER Department head nurses by providing the above information and asking them to support the idea in the nursing administration. Then both will help in persuading the hospital administration.

3- Choosing the best tow qualified nurses to send them outside for six month’s to get specialized courses in pain management. (the selection criteria will include having at least five years experience to be familiar with rules and regulation of the institution and appear to work the same institution at least 4 years after returning back.

4- Formulate health education program to improve nurse's practices in pain assessment and management. The purpose of the health education program is to change nurse's ideas and behaviors about pain assessment and management. (We have enclosed an example on health education program appendix A).

5- The participation in the health education program will be obligatory and exam will be done after finishing.
6- Creating a pain assessment and management standards and protocols sheet and activate the use of it.

7- Induce new position's requirements with explaining duties and preparing a list of medications which they will be allowed to prescribe.

8- Evaluation for the educational program will be done by observing and recording the attitudes of nurses toward pain assessment and management.

9- Evaluation for the performance of pain management specialist nurse will be done by observing their effectiveness in the clinical area and the level of patient's satisfaction in the clinical area.

10- At the end, both advantages and disadvantages of the application will be evaluated and discussed with the administration.

We will use the empirical rational strategy, which assumes that people are rational and adopt change if it is rationally justified. Also, we will decrease the risk of resistance by:

1- Communication with those who opposing the change and convincing them by clarifying information and provide accurate feedback

2- Also, making the goals of change is unified and focusing on the positive consequences and minimizing the negative consequences is useful strategy for reducing resistance.

3- Maintain a climate of trust and support and confidence between nurses will help in decreasing the resistance that we may face.

The third stage is refreezing stage, which is defined as the stage of integration and stabilization of the new change. The indications for achieving this change are:
1- The change of the nurse's behaviors and attitudes toward pain assessment and management.

2- Applying of new position as a part of the policy of the ER Department presenting a documented job description for it and integrating the new position on the organizational structure.

After this we will try to stabilize the new condition by supporting its application and modifying any problem arises later.

The implication of this project:

1- Creating a standards and protocols for pain assessment and management in ER Department will ensure an accurate and systematic way of assessing and managing pain and will activate the participation of the nurses in the process.

2- Changing the attitudes and the behaviors of the nurses toward pain assessment and pain management will minimize the suffering of the patients from inadequate pain management.

3- The presence of the pain management nurse specialist will be the gate toward enhancing the moving toward specialization in nursing.

4- The success of implementing this project will create a more comfortable environment for the nurses to work effectively.

5- The quality of care will be improved by implementing this project (the patients are more satisfied and comfortable).

6- Implementing this project will enhance and increase staff development process. Also, it will increase the effective participation of the nurses in the health care process.
Recommendation

Delay in analgesia or poorly managed pain remains for emergency staff an important ethical, moral and clinical issue. Delay in pain management often occurs as a result of increased patient presentations, the need for a medical drug order, and/or medical assessment (Williams and Sen, 2000). While patients in pain are often allocated a higher triage code and should be seen by a doctor more quickly, this does not always ensure the timely delivery of analgesia (Fry et al., 1999).

Innovative pain management strategies that target the early delivery of analgesia will improve Patient outcomes and early relief and control of a patient’s pain have been shown to have a positive influence on the patient’s well being and emergency experience.

Knowing that and building over it we recommend the following points to enhance the pain handling in the ED:

1- Further study the problem of pain assessment in the ED to explore its dimensions and find out the best possible solution for it.
2- Enhancing the Nurses Knowledge in pain assessment and management strategies and integrating such knowledge in the field of practice.
3- Changing some misleading concepts in the ED that affect the proper assessment and management of pain.
4- Introducing the role of pain management nurse specialist as a proper scientific method to solve such an important solution.
5- Following up any implemented solution to ensure it's accurate implementation.

Conclusion

This study tried to highlight the phenomena of inadequate pain assessment and management activities in the ED in Islamic and University hospitals. Asserting on the fact that Pain is the most common symptom that people present with to an emergency department And that Increased patient dissatisfaction can result when delays in analgesic management occur. Appropriate Strategies and algorithms should be addressed to contribute in solving this problem, providing a guide for Nurses, better management for pain and thus enhancing patient experience in the ED.
Any successful change should be a planned one so in this study we tried to employ Lewins change theory and role transition theory, to enhance the nurses practice in the ED and introduce the new role of pain management nurse specialist so that they will be more sensitive, initiative and effective in assessing and managing pain.
References


Appendix (A): Pain assessment sheet (Standards and protocols for pain assessment)

**P** (Provocative or Palliative)

What makes the pain better?

..........................................................................................................................................

......

What makes the pain worse?

..........................................................................................................................................

......
Q (Quality of Pain)

☐ Somatic Pain
  ☐ Localized
  ☐ Aching
  ☐ Throbbing

☐ Visceral Pain
  ☐ Deep
  ☐ Cramping
  ☐ Referred
  ☐ Aching or Gnawing

☐ Neuropathic Pain
  ☐ Burning
  ☐ Piercing
  ☐ Lacerating
  ☐ Prickling

☐ Others

(Describe the Pain?

........................................................................................................................................

R (Radiation of Pain)

☐ Over all the Body

  Or

☐ Determine the Site
Severity (Severity of the pain)

Numerical Pain Scale
Faces Pain Scale
(For children or persons with cognitive impairment)

Timing (Onset & duration of Pain)

Time of Starting 

Duration of Pain 

Occur in association with:

- Eating
- Exertion
- Others

Physical assessment
Inspection

Observable sign and symptoms of pain present

- □ Grimacing
- □ Withdrawal
- □ Clenching of the teeth and Hands
- □ Assuming a fatal posture

Auscultation

Auscultation for the site of the pain

………………………………………………………………………………

…

Palpation

Palpate a round the area of Pain

………………………………………………………………………………

…

Communication of Assessment finding

Act as advocate for the patient

Communicate the finding for the physician

- □ Yes
- □ NO
Appendix (B): Pain management sheet

Pharmacological Measures Principles

- **Severe Pain**
  - Step 3
  - NSAIDs +/- Adjuvants +/- Non-pharmacological measures +/- add a strong opioid

- **Moderate Pain**
  - Step 2
  - NSAIDs +/- Adjuvants +/- Non-pharmacological measures + add a mild opioid

- **Mild Pain**
  - Step 1
  - NSAIDs +/- Adjuvants +/- Non-pharmacological measures

Document the pharmacological measures that have been made?

...
- Non-Pharmacological measures
  - Relaxation technique
  - Distraction and Guided Imagery
  - Changing the meaning of the pain

Appendix (C): Opioids, Adjuvant and Non-Opioids tables

### Commonly used Non-Opioids

<table>
<thead>
<tr>
<th>Non-Opioid</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>650-975 mg q 4 hr</td>
<td>10-15 mg/kg q 4 hr</td>
<td>Acetaminophen does not have anti-inflammatory properties Contraindicated in liver failure or disease</td>
</tr>
<tr>
<td>Aspirin</td>
<td>650-975 mg q 4 hr</td>
<td>10-15 mg/dg q 4 hr</td>
<td>Inhibits platelet aggregation</td>
</tr>
<tr>
<td>Choline magnesium trisalicylate (Trilisate)</td>
<td>1000-1500 mg bid</td>
<td>25 mg/kg bid</td>
<td>May have minimal anti-platelet activity Available as an oral liquid</td>
</tr>
<tr>
<td>Ibuprofen (Motrin, others)</td>
<td>400 mg q 4-6 hr</td>
<td>10 mg/kg q 6-8 hr</td>
<td>Available as several brand names and as generic Available in oral suspension</td>
</tr>
<tr>
<td>Ketoprofen (Orudis)</td>
<td>25-75 mg q 6-8 hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Magnesium salicylate</td>
<td>650 mg q 4 hr</td>
<td></td>
<td>Many brands and generic forms available</td>
</tr>
<tr>
<td>Naproxen (Naprosyn)</td>
<td>500 mg initial dose followed by 250 mg q 6-8 hr</td>
<td>5 mg/kg q 12 hr</td>
<td>Available as oral liquid</td>
</tr>
<tr>
<td>Naproxen sodium (Anaprox)</td>
<td>250 mg initial dose followed by 275 mg q 6-8 hr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketorolac tromethamine (Toradol)</td>
<td>30 or 60 mg IM/IV initial dose followed by 15 or 30 mg q 6 hr Oral dose following IM/IV dosage: 10 mg q 6-8 hr</td>
<td></td>
<td>Intramuscular/Intravenous dose not to exceed 5 days</td>
</tr>
<tr>
<td>Drug Class</td>
<td>Drug Name</td>
<td>Normal Adult Dose</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------</td>
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<td>-------------------</td>
<td>--------------------------------------------------------------------------</td>
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<tr>
<td>Corticosteroids</td>
<td>Dexamethasone</td>
<td>4-16mg per day</td>
<td></td>
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<tr>
<td></td>
<td>(Decadron)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Amitriptyline</td>
<td>25-150 mg qhs</td>
<td>Titration upwards should occur every 3-5 days by 25 mg increments for</td>
</tr>
<tr>
<td></td>
<td>(Elavil)</td>
<td></td>
<td>desired dose</td>
</tr>
<tr>
<td></td>
<td>Imipramine</td>
<td>25-150 mg qhs</td>
<td>Titration upwards should occur every 3-5 days by 25 mg increments for</td>
</tr>
<tr>
<td></td>
<td>(Tofranil)</td>
<td></td>
<td>desired dose. Imipramine is less sedating</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Gabapentin</td>
<td>300mg qd X 1 then</td>
<td>Maximum dose = 3600 mg/day</td>
</tr>
<tr>
<td></td>
<td>(Neurontin)</td>
<td>300 mg qd X2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>titrating to pain</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>relief. Begin with</td>
<td></td>
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<tr>
<td></td>
<td>Valproic Acid</td>
<td>250 mg TID and</td>
<td></td>
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<tr>
<td></td>
<td>(Depakote)</td>
<td>titrate</td>
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</tbody>
</table>
### Equianalgesic Dose Chart

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose (mg) Parenteral</th>
<th>Dose (mg) Oral</th>
<th>Duration (hour)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10</td>
<td>30</td>
<td>3-4</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>1.5</td>
<td>7.5</td>
<td>3-4</td>
</tr>
<tr>
<td>Oxycodone (Oxycontin)</td>
<td>20-30</td>
<td>2-3</td>
<td>3-4</td>
</tr>
<tr>
<td>Levorphanol (Levo-Dromoran)</td>
<td>2</td>
<td>4</td>
<td>6-8</td>
</tr>
<tr>
<td>Methadone</td>
<td>2-5</td>
<td>6-12</td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>200</td>
<td>3-4</td>
<td></td>
</tr>
<tr>
<td>Hydrocodone (Vicodin)</td>
<td>30-75</td>
<td>3-4</td>
<td></td>
</tr>
<tr>
<td>Meperidine (Demerol)</td>
<td>100</td>
<td>3-4</td>
<td></td>
</tr>
<tr>
<td>Fentanyl (Duragesic)</td>
<td>0.1-0.25 mg (100-250 mcg)</td>
<td>Microgram per hour dose of transdermal fentanyl approximates 1/3 of the milligram per day dose of oral morphine up to 200 mg per day</td>
<td>72</td>
</tr>
</tbody>
</table>

(McCaffery and Pasero, 1999)

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**Appendix (D): Additional suggested Tools for pain assessment and management.**

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**Interdisciplinary Pain Management Team Nursing Assessment and Care Plan**

### Identifying Information

<table>
<thead>
<tr>
<th>Identification</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Medical Record Number:</td>
<td></td>
</tr>
<tr>
<td>Sex: M F</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Primary Physician:</td>
<td></td>
</tr>
<tr>
<td>Surgical History:</td>
<td></td>
</tr>
<tr>
<td>Marital Status: S M D W</td>
<td></td>
</tr>
<tr>
<td>Primary Relationship:</td>
<td></td>
</tr>
<tr>
<td>Emergency Phone: ( )</td>
<td></td>
</tr>
<tr>
<td>Advanced Directive: Yes / No</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
</tbody>
</table>
Ethnicity: Specify:

Language: Spanish
English
Other

Code Status:

Primary Diagnosis:

Other Diagnoses:

**Pain Assessment**

1. Location/Cause:
   
   A.
   
   B.
   
   C.

2. Intensity: Patient rating (0-10) Average: Best pain gets: At present: Acceptable level of pain: Worst pain gets:

   1. 3. Quality: Patient’s own words (i.e. ache, burn, throb, etc.)
   2. 4. Onset, duration, variations:
   3. 5. What relieves pain:
   4. 6. What causes or increases the pain:

**Summary:**

**Location Cause* Average Intensity (0-10) Descriptive Code**

A.

B.

C.

* Causes: Malignant, Non-Malignant
Previous Experience with Pain Impact Scale

<table>
<thead>
<tr>
<th>Activity</th>
<th>0 = not effective</th>
<th>Activity</th>
<th>0 = not effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biofeedback/Relaxation</td>
<td></td>
<td>Psychotherapy</td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td></td>
<td>Heat/Cold</td>
<td></td>
</tr>
<tr>
<td>Bedrest</td>
<td></td>
<td>Massage/Rubbing</td>
<td></td>
</tr>
<tr>
<td>Group Therapy</td>
<td></td>
<td>Prayer</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td>Accupressure</td>
<td></td>
</tr>
<tr>
<td>Distraction</td>
<td></td>
<td>Accupuncture</td>
<td></td>
</tr>
<tr>
<td>TENS Unit</td>
<td></td>
<td>Brace</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physical Examination

**Vitals**: Pulse BP RR
**Mental Status**: Alert Oriented Somnolent
Lethargic Comatose
Skin: HEENT: Chest: Cardiac: Abdomen: Extremities:
Neurological:

**Psychosocial Assessment Overall impact score:**

**Psychosocial Issues Interviewer Patient**

1. 1. Economic: _____________________________
2. 2. Emotional: _____________________________
3. 3. Social Support/Intimacy: _____________________________
4. 4. Coping Techniques: _____________________________
5. 5. Activities of Daily Living: _____________________________
Associated Symptoms Patient rates if present on scale (0-10)

Nausea: Diarrhea:

Vomiting: Constipation

Anxiety: Depression:

Insomnia: Shortness of Breath:

Anorexia: Fatigue:

Sedation: Pruritus:

Other:
Drug History Form

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<th>SIG</th>
<th>INDICATION</th>
<th>START DATE</th>
<th>END DATE</th>
<th>MD</th>
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# Appendix (E): Pain Assessment Flow Sheet

## Source of Information:
- **Patient ?**
- **Child ?**
- **Parent ?**
- **Nurse ?**

## ST. FRANCIS REGIONAL MEDICAL CENTER
**WICHITA, KANSAS**

## PAIN FLOW SHEET

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Location of Pain</th>
<th>Pain Rating (0-10)</th>
<th>Pharmacologic/Nonpharmacologic</th>
<th>Mode of Administration</th>
<th>Source of Information</th>
<th>BP</th>
<th>F</th>
<th>R</th>
<th>LOC</th>
<th>Side Effects/Response/Comments</th>
<th>Evaluation of Intervention/</th>
<th>Initials</th>
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## Mode of Administration
- **PCA**
- **IV**
- **EM**
- **Epidural**

## Side Effects
- **Nausea/Vomiting**
- **Respiratory Depression**
- **Puritus**
- **Urinary Retention**
- **Altered Mental Status**

## Mental Status
- **Alert**
- **Oriented x3**
- **Disoriented**
- **Confused**
- **Incomprehensible Sounds**
- **Lethargic (Sleeping but when stimulated obey simple commands)**
- **Semicomatoses (Purposeful movements when stimulated. Doesn't obey commands or answer questions. Doesn't talk at all.)**
- **Coma (Deeply comatose. Draws hands up onto chest when stimulated, but not purposefully.)**

## Nonpharmacologic Interventions
- **Cold**
- **Distractions**
- **Environmental Control**
- **Exercises**
- **Heat**

## Pharmacologic Administration
- **SQ**
- **PO**
- **Patch**
- **Infusion**

## Pediatrics
- **Imagery**
- **Massage**
- **Music**
- **Positioning**
- **Relaxation**

## Pediatrics only (1-10 scale)
- **Holding**
- **Rocking**
- **Pacifier**
- **Security object**

## A. Verbal/Vocal
- **1** = positive
- **2** = neutral

## B. Body Movements
- **1** = moves easily
- **3** = pain

## C. Facial
- **1** = smiling
- **3** = frown, grin

## D. Touching (localizing pain)
- **1** = no touching
- **3** = grabbing

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Pediatrics</th>
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<td>* Cold</td>
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<td>* Relaxation</td>
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Appendix (C): Health education program

(Health education program)

OUTLINE SUMMARY

Introduction

Principles

Program Objectives

Course Objectives

Curriculum Content Outline

I. Introduction

II. Definitions of pain

III. Pain as a multidimensional phenomenon

IV. Pain Measurement and Assessment

V. Pain Management of Acute, Recurrent, Chronic Nonmalignant, and Malignant Pain

VI. Impact of pain and unrelieved pain

Introduction

Pain is a multidimensional and complex phenomenon, requiring that effective assessment and management be based on current knowledge. Many disciplines are involved, directly and indirectly, in working toward the effective management of pain experienced by patients in a variety of clinical settings.

The nurse is one of the health-care professionals who has frequent contact with patients receiving care in the community, at home, or in inpatient or outpatient settings. This frequent contact puts the nurse in a unique position to identify the patient who has pain; to appropriately assess the pain and its impact on the patient, the patient's family, and health professionals; to initiate action to alleviate the pain using available resources; and to evaluate the effectiveness of those actions.
As a result of this central role and responsibility in the assessment and management of pain, nurses can be expected to be knowledgeable about pain mechanisms and theories, the epidemiology of pain, frequently encountered pain syndromes, variables which influence the patient’s perception of and response to pain, valid and reliable methods of clinical pain assessment, and a range of available methods for the alleviation of pain. Successful management of pain depends as much on care as on cure. If health professionals cannot eliminate the pain, nurses can reduce suffering often associated with unrelieved pain. Implementation of this curriculum depends on application of interpersonal communication, and patient advocacy skills which are included in nursing education. In pain management, how the nurse does it may be as important as what the nurse does.

Principles

The following principles guide the pain curriculum for graduate nurses:

1. Pain is viewed as a multidimensional experience that has many components in addition to nociception. These include sensory, emotional, cognitive, developmental, behavioral, and cultural components, all of which may influence pain perception and response.

2. Pain must be regularly and appropriately assessed in systematic ways and the assessment should be considered a necessary part of management.

3. Pain assessment and management, integral aspects of nursing care, must involve the patient and be ongoing.

4. Pain assessment and management must be recorded in a readily accessible and visible manner; pain assessment serves as a guide to intervention not as an end in itself.

Program Objectives

Upon completion of basic education in nursing, the graduate will be able to:
1. Conceptualize pain as a distinct and frequently encountered human problem in the healthcare of patients, irrespective of age, gender, or cultural background.

2. Describe and understand current knowledge of the anatomy, physiology, pharmacology and psychology of pain.

3. Describe and utilize common assessment tools, developed and tested to examine perceived pain, and evaluate their usefulness and applicability across a variety of practice settings.

4. Describe interventions currently used to manage pain. Determine the appropriateness and utility of interventions to be provided by nurses in terms of patient outcomes.

5. Recognize that pain management involves treatment of the multiple dimensions of the pain experience.

6. Describe basic pharmacodynamic and pharmacokinetic properties of the most commonly used pharmacological therapies for pain, including synergism.

7. Evaluate specific nursing pain management techniques in relation to established theories and current research.

8. Use appropriate psychomotor skills to apply pain relief measures in clinical practice.

9. Discuss ethical and legal issues related to pain and pain management.

10. Demonstrate effective collaboration as a nurse-member of a multidisciplinary team in the management of pain.

Course Objectives

At the end of the basic education course on the subject of pain and pain management, the nursing student will be able to:

1. Describe the similarities and differences among definitions of pain, from a selected range of scientific and cultural perspectives.

2. Describe the potential influences of variables, such as stress, anxiety, fear, and fatigue, on pain perception and response.
3. Describe current concepts of pain and pain management.

4. Describe the sensory, cognitive, affective, and behavioral components of pain.

5. Describe the roles of family and culture in the development of attitudes toward pain.

6. Describe, at a beginning level, the concepts of reliability and validity, as they relate to instruments designed to assess and/or measure pain.

7. Evaluate instruments for pain assessment for their adequacy and utility, referring to specific patient populations in clinical practice, including different age groups.

8. Describe and utilize the most common, current methods of pain management and their side effects: pharmacological and non pharmacological.

9. Develop and evaluate effective pain protocols in conjunction with patients, physicians, pharmacists, and psychologists when appropriate, for patients in clinical practice using both pharmacological and non pharmacological methods.

10. Describe and demonstrate nursing skills in using common techniques for pain management.

11. Evaluate specific nursing interventions, in relation to theory, development, and research.

12. Evaluate one's own role beliefs, and attitudes, as well as of other healthcare professionals, in relation to pain management in clinical practice.

Curriculum Content Outline

I. Introduction

A. Magnitude of problem - epidemiology

B. Personal, economic and social impact

C. Ethical, legal, and political issues

D. Life span considerations

E. Facilitators of and barriers to pain assessment and management (patient, family, health professionals, institutions, society)
II. Definitions of pain
   A. Types of pain (acute, recurrent, chronic, and cancer)
   B. Differentiation between pain, nociception, suffering, and pain behaviors
   C. One-dimensional vs. multidimensional definitions
   D. Evolution of pain theories

III. Pain as a multidimensional phenomenon
   A. Physiological Dimension - neural mechanisms of pain
      1. Peripheral pain mechanisms (transductions and transmission)
      2. Dorsal horn processing
      3. Central ascending pain pathways
      4. Ascending and descending pain modulation
      5. Physiological and pathological consequences of unrelieved pain
   B. Sensory Dimension
      1. Location
      2. Intensity
      3. Quality
      4. Temporal pattern
   C. Affective Dimension
      1. Influence of negative emotions
      2. Influence of optimistic emotions
      3. Affective consequences of pain, including suffering
   D. Cognitive Dimension
      1. Influence of personal beliefs and attitudes about and meanings attached to pain and the medical condition associated with the pain (if present)
      2. Self-efficacy, self control, locus of control
3. Pain attribution

4. Impact of spiritual beliefs, culture, and family on cognitive responses to pain.

E. Behavioral Dimension

1. Response to stressors (situational, developmental)

2. Pain expression behaviors

3. Pain control behaviors

4. Usual behaviors prevented by pain

F. Psychopathological Dimension (pain as a symptom of psychiatric illness)

IV. Pain Measurement and Assessment

A. Appropriateness, validity, and reliability of assessment methods for specific age groups and clinical context

B. One-dimensional methods (physiological, behavioral, self-report)

C. Multidimensional methods

D. Recording pain assessments and measurements

V. Pain Management of Acute, Recurrent, Chronic Non malignant, and Malignant Pain

A. Therapeutic goals (patient, family, health professional, society)

B. Pharmacological strategies - interdependent roles: patient as well as nursing and medical disciplines (include onset, peak; duration of effects)

1. Patients ideas and misconceptions.

2. Non steroidal anti inflammatory agents

3. Systemic and spinal opioids (include differentiation of addiction, dependence, and tolerance).

4. Local anesthetics

5. Other drugs (anticonvulsants, antidepressants, anti neoplastic agents)

6. Methods of drug delivery
a. enteric
b. parenteral
c. infusion devices
d. PCA

7. Age specific issues

C. Non pharmacological strategies - interdependent roles: patients as well as nursing, medicine, psychology, and other disciplines.

1. Physical strategies (exercise, turning and positioning, wound support, therapeutic touch, massage, special mattress, heat, cold hydrotherapy, etc.)

2. Psychological and behavioral strategies (psychotherapy, cognitive- behavioral therapy, relaxation techniques, hypnotherapy, operant approaches, stress management, patient and family education and counseling, self-help groups, music, humor, biofeedback).

3. Neurostimulation (transcutaneous nerve stimulation, acupuncture, epidural stimulation, brain and spinal cord stimulation)

4. Neuroablative strategies (neurolytic nerve blocks, neurosurgical techniques)

5. Radiotherapy (cancer pain).

D. Multimodality and multidisciplinary pain management

1. Role of each discipline

2. Unique contribution from nursing

3. Palliative care, including hospice and home care

4. Patient education

5. Integration and coordination of care

E. Monitoring and management of desired effects and side effects of pain management strategies (continuing care)

1. Follow-up evaluation of therapeutic effect and patient needs
2. Follow-up evaluation of patient and family responses to treatment

VI. Impact of pain and unrelieved pain

A. Impact of acute pain on recovery from surgery or illness

B. Impact of chronic malignant pain and chronic nonmalignant pain on:
   1. The individual (physical, psychological, vocational, socioeconomic)
   2. The family (roles, relationships, psychological, socioeconomic)

C. Pain resolution and predictors of chronicity

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