

Standard 33

Revised: 2003, 2006, 2009
Reviewed: 1991, 1994, 1997, 2000

THE PATIENT IN PAIN

OBJECTIVES:

1. To minimize/manage pain.
2. To prevent secondary complications and prevent injury.

PROCESS STANDARDS:

1. The patient will be positioned for optimal comfort.
2. Expression of fears and anxieties will be encouraged as well as diversional activities, such as radio and TV.
3. The patient's need for pain management will be assessed on admission. If pain was identified on admission, a more comprehensive assessment will be performed including, but not limited to, pain location, intensity, character, duration, what improves/increases pain, pain treatment goal and/or pain management history. Reassessment will be performed as indicated.
4. If no pain was identified on admission, a reassessment for pain will be performed as warranted by patient condition, anytime the patient complains of pain, and/or post invasive procedure.
5. The Numerical Pain Intensity Scale, Wong-Baker FACES Pain Rating Scale, CPOT (Critical-Care Pain Observation Tool), CNPI (Checklist of Nonverbal Pain Indicators) or FLACCr Pain Scale will be used to assess pain intensity.
6. The patient's report of pain will be accepted as the key indicator of the amount of pain he/she is experiencing.
7. The patient/family will receive information and education regarding pain, risk factors, use of pain assessment scale, methods for pain management, side effects, etc. Patient education and level of understanding will be documented in the 24 Hour Nurses Notes, Knowledge Problem/Priority section or on the Inter-Disciplinary Patient Education Record (IPEF, SN 1102).
8. The Pain Management Service will be consulted, by the physician, as needed.
9. The physician will be notified, unless otherwise ordered, when pain scores are 5 or greater on a 10 point scale and/or anytime pain is unacceptable to the patient.
10. External stimuli during acute episodes of pain will be controlled, i.e., darkened room, quietness.
11. Consider nonpharmacological therapies for pain relief such as massage, imagery, music, therapeutic touch, relaxation, etc.
12. Administer pain relief medication as ordered.

OUTCOME STANDARDS:

Prior to discharge:

1. The patient will experience minimal side effects from analgesic regimen.

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Prior to discharge continued:

2. The patient will report satisfaction of pain management and pain relief, and pain score will be documented upon discharge.
3. The patient will communicate understanding of pain management at home and other follow-up are as appropriate to his/her care.

HAVE I DOCUMENTED:

- * Activity tolerance
- * Pain medication
 - Time given
 - Route
 - Patient response
- * Pain assessment and score at appropriate intervals
- * Call bell
- * Patient education
 - Safety measures
 - Pain management and other follow up care
 - Use of diversional activities, such as TV, radio encouraged
 - Use of nonpharmacological therapies such as imagery, relaxation, therapeutic touch, etc.

At The Time of Discharge:

- * Pain will have been managed appropriately
- * Patient/family has understanding of home and follow-up care regarding pain and whom to contact should problems occur.

Reference:

1. Doenges, M., Moorhouse, M.F., and Murr, A. Nurses Pocket Guide: Diagnosis, Prioritized Interventions, and Rationales-10 ed. (2008). *Acute Pain*. Philadelphia: F.A. Davis.
2. Doenges, M., Moorhouse, M.F., and Murr, A. Nurses Pocket Guide: Diagnosis, Prioritized Interventions, and Rationales-10 ed. (2008). *Chronic Pain*. Philadelphia: F.A. Davis.
3. Hospital Policy 5.34.0 Pain Management
http://www.sh.lsuhsu.edu/policies/policy_manuals_via_ms_word/hospital_policy/h_5.34.0.pdf
4. Nursing Policy P-05 Pain Management Flowsheet
http://www.sh.lsuhsu.edu/policies/policy_manuals_via_ms_word/Nursing/P-05.pdf