SUBJECT: **PAIN ASSESSMENT**
APPROVED BY: VP Acute & Long Term Care & COO(South)_____
EFFECTIVE DATE: 2007 10 23
REVISED DATE:
REVIEW DATE:

Purpose

To provide continuity in assessing pain for all clients

To provide clients with adequate pain control.

To inform nurses of the potential for under-treating pain and allow them to fully pursue and evaluate the client with pain.

Policy/Standard:

Definition of Pain: Pain is whatever the experiencing person says it is, existing whenever they say it does, (Nursing Administration Policy G-1-27).

The type of pain that the patient describes may be caused by actual or potentially damaging stimuli to tissue (skin, muscle, bone, organs), or nociceptive pain. If it is caused by a primary lesion or dysfunction in the nervous system, it is referred to as neuropathic pain. Some patients may have both types, or pain of mixed etiology.
Individual self-report remains the most reliable indicator of pain, include pain descriptors used by the client, such as a pinching, squeezing or may use the term “discomfort” which may mean achy, sore, or uncomfortable. Once a term to describe an individual’s pain has been identified, it is recommended that this term be used throughout the assessment and reassessment of that individual’s pain.

Materials Required:

Comprehensive Pain Assessment Tool (G-1-27-1)

Related Policies:

(G-1-27)

Procedure:

Nurses must:

1. Evaluate the present pain complaint, characterize an individual's pain by: assessing type, quality, radiation, timing, location, intensity and etiology.

2. Included is a review of alleviating and aggravating factors that make the pain better, worse, and what treatments have been used as well as the client's response to treatment.

3. Take a detailed history, including characterization of the present pain complaint, pain related history, and the impact of the pain on the client's quality of life.

4. Take a history of liver, gastrointestinal, and kidney dysfunction. This is important to elicit as clients suffering with these medical conditions may require alterations to their pharmacologic treatment options.

5. Take a complete medication history, including prescribed, over-the-counter, herbal remedies and alcohol consumption because they are necessary and must be considered when making analgesic choices.

6. Must complete a thorough physical exam and ensure appropriate diagnostic exams are ordered within their scope of practice.

7. Assess for Peripheral vascular disease, Diabetes, Post stroke syndrome, Decubitus ulcers, Oral/dental problems, Contractures, Abdominal pain, Cardiovascular pain, Degenerative joint disease, Rheumatoid Arthritis, previous fractures and Osteoporosis.

8. Must complete the comprehensive pain Assessment Tool (G-1-27-1).

9. Document finding in the patient chart.

10. Departmental Audits will be completed Annually. (see Appendix A).

Assessment Tools

Several assessment tools are available to evaluate the intensity and location of the pain complaint. There are four methods for pain measurement: the numerical rating scale, verbal rating scale, visual analog scale and FACES pain rating scale. The Community clinic Services has adopted the Pain Assessment Tool which incorporates all aspects all for a comprehensive assessment of pain.

Nurses' signature and a number must be clearly documented at the end of each assessment.

Resources:

Medscape Nursing: Clinical Assessment of Pain
http://www.medscape.com/viewarticle/556382

Nursing Administration Policy – Pain Assessment-Comprehensive G-1-27
http://lghealth/policies/files/Pain%20Assessment%20-%20Comprehensive%20Tool%20G-1-27-1%20final.pdf

Nursing Administration Policy – Pain management G-1-28
http://lghealth/policies/files/Pain%20Assessment%20-%20Comprehensive%202010%20G-1-27.pdf

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Appendix A

Pain Assessment Audit Tool

Auditor Name: _____

Date: _____

Location: _____

Next Audit date: _____

Sample #	Was the Comprehensive Pain Assessment Tool completed?		Comments
	Yes	No	
1			
2			
3			