O-110 Pain Assessment

Purpose

Assess client level of pain.

Identify treatments or other factors that alleviates pain.

Identify factors that increase or enhance pain.

Promote comfort.

Applies To

Registered Nurses

Licensed Practical/Vocational Nurses

Other (*Identify*): ____

Equipment/Supplies

Pain Assessment tool

Special Considerations

Many home care clients experience chronic pain related to long term diseases or functional limitations.

Each person’s perception of pain is individual. It may be diminished in the elderly.

Specific diseases or complications of illness may impair the client's ability to define or report pain. Use very specific questions and use visual facial descriptions of pain for clarification.

Clients may be unwilling to take medications for pain or under report the degree of pain. Look for alternatives to drugs to control or alleviate pain.

Procedure

1. Wash hands. Refer to the Hand Washing Procedure.
2. Explain the procedure to the client.
3. Assess these parameters when the client is experiencing pain.
    a. Location of the client's pain.
    b. What actions or situations increase pain?
    c. What actions or situations relieve pain?
    d. Quality of the pain as described by the client (dull, sharp, constant, etc.).
    e. Assess associated symptoms observed and reported: nausea, vomiting, tachycardia, increased respirations, shallow respirations, etc.

4. On a scale of one to ten or other measurable scale, record the client's rating of their pain. Visual aids may be helpful in describing pain.
5. Effect pain is having on daily activities and quality of life.
6. Medication/treatment history and their effectiveness in controlling pain. Note any history of drug abuse or misuse.
7. Mood changes as a result of the pain
8. Discuss pain management intervention options and assess their preferences.
9. Implement treatment plan.
10. Evaluate the effectiveness of the treatment or medication.
11. Assess pain at regular intervals and whenever there is a new or exacerbated report of pain.
12. Specifically assess response to any intervention - pharmacologic or not.
13. Instruct client on the assessment process and measurement tool so the reports are reflective of client need and response.

Documentation Guidelines

Document in the client record:

1. General status of client including vital signs.
2. Client description of pain including location, quality, and self rating of the pain.
3. Treatments/interventions and response.
4. Physician notification as appropriate.
5. Other findings.

Related Procedures

Medication Administration, Assessment Procedures

Policy History

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