11.5: Applying the Nursing Process

Assessment

Nurses play an essential role in performing comprehensive pain assessment. Assessments include asking questions about the presence of pain, as well as observing for nonverbal indicators of pain, such as grimacing, moaning, and touching the painful area. It is especially important to observe for nonverbal indicators of pain in patients unable to self-report their pain, such as infants, children, patients who have a cognitive disorder, patients at end of life, non-English speaking patients, or patients who tend to be stoic due to cultural beliefs. See Figure 11.14\(^1\) for an image of a patient who is expressing pain nonverbally.
Recall that pain is defined as whatever the person experiencing it says it is. Subjective assessment includes asking questions regarding the severity rating, as well as obtaining comprehensive information by using the “PQRSTU” or “OLDCARTES” methods for assessing a chief complaint. For some patients who are unable to quantify the severity of their pain, a visual scale like the FACES scale is the best way to perform subjective assessment regarding the severity of pain.

Objective data includes observations of nonverbal indications of pain, such as restlessness, facial grimacing and wincing, moaning, and rubbing or guarding painful areas. For patients who cannot verbalize their pain, using a scale like the FLACC, COMFORT, or PAINAD is helpful to standardize observations across different staff members. Keep in mind that patients experiencing acute pain will also likely have vital signs changes, such as increased blood pressure, increased heart rate, and increased respiratory rate.

It is important to assess the impact of pain on a patient’s daily functioning. This can be accomplished by asking what effect the pain has on their ability to bathe, dress, prepare food, eat, walk, and complete other daily activities. Assessing the impact of pain on daily functioning is a new standard of care that assists the interdisciplinary team in tailoring treatment goals and interventions that are customized to the patient’s situation. For example, for some patients, chronic
pain affects their ability to be employed, so effective pain management is vital so they can return to work. For other patients receiving palliative care, the ability to sit up and eat a meal with loved ones without pain is an important goal.\textsuperscript{[2]}

When performing a patient assessment, any new complaints of pain or pain that is unresponsive to the current treatment plan should be reported to the health care provider. Instances of sudden, severe pain or chest pain require immediate notification or contact of emergency services.

### Diagnoses

Commonly used NANDA-I nursing diagnoses for pain include \textit{Acute Pain} (duration less than 3 months) and \textit{Chronic Pain}. See Table 11.5 for more information regarding these diagnoses.\textsuperscript{[3]} For more information about defining characteristics and related factors for other NANDA-I nursing diagnoses, refer to a current nursing diagnosis resource.

Table 11.5 Pain NANDA-I Nursing Diagnoses\textsuperscript{[4]}

<table>
<thead>
<tr>
<th>NANDA-I Diagnosis</th>
<th>Definition</th>
<th>Defining Characteristics</th>
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| **Acute Pain**    | Unpleasant sensory and emotional experience associated with acute or potential tissue damage, or described in terms of such damage; sudden or slow onset of any intensity from mild to severe with an anticipated or predictable end, and with a duration of less than 3 months. | • Alteration in sleep pattern  
• Appetite change  
• Change in physiological parameters (i.e., blood pressure, heart rate, respiratory rate)  
• Diaphoresis  
• Distraction behavior  
• Evidence of pain using standardized pain behavior checklist for those unable to communicate verbally  
• Expressive behavior  
• Facial expression of pain  
• Guarding |
Chronic Pain

Unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (International Association for the Study of Pain); sudden or slow onset of any intensity from mild to severe, constant or recurring without anticipated or predictable end, and with a duration of greater than 3 months.

- Hopelessness
- Narrowed focus
- Protective behavior
- Proxy report of pain behavior/activity changes
- Pupil dilation
- Restlessness
- Self-focused
- Self-report of intensity using standardized pain scale
- Self-report of pain characteristics using standardized pain instrument
- Altered in ability to continue previous activities
- Alteration in sleep pattern
- Anorexia
- Evidence of pain using standardized pain behavior checklist for those unable to communicate verbally
- Facial expression of pain
- Proxy report of pain behavior/activity changes
• Self-focused
• Self-report of intensity using standardized pain scale
• Self-report of pain characteristics using standardized pain instrument

Outcome Identification

An overall goal when providing pain management is, "The patient will report that the pain management treatment plan achieves their comfort-function goals."[5]

SMART outcomes are customized to the patient’s unique situation. An example of a SMART goal is, “The patient will notify the nurse promptly for pain intensity level that is greater than their comfort-function goal throughout shift.”[6]

Planning Interventions

Several pharmacological and nonpharmacological interventions have been described throughout this chapter. See the following box for a summarized list of interventions for acute pain management.

Acute Pain Management[7]

• Identify pain intensity during required recovery activities (e.g., coughing and deep breathing, ambulation, transfers to chair, etc.)
• Explore patient’s knowledge and beliefs about pain, including cultural influences
• Question patient regarding the level of pain that allows a state of comfort and desired function and attempt to keep pain at or lower than identified level
• Ensure that the patient receives prompt analgesic care before the pain becomes severe or before pain-inducing activities
• Administer analgesics around-the-clock as needed the first 24 to 48 hours after surgery, trauma, or injury except if sedation or respiratory status indicates otherwise
• Monitor sedation and respiratory status before administering opioids and at regular intervals when opioids are administered
• Follow agency protocols in selecting analgesia and dosage
• Use a combination of prescribed medications (e.g., opioids, nonopioids, and adjuvants), if pain level is severe
• Select and implement interventions tailored to the patient’s risks, benefits, and preferences (e.g., pharmacological and nonpharmacological) to facilitate pain relief
• Cautiously use analgesics that may have adverse effects in older adults
• Administer analgesics using the least invasive route available, avoiding the intramuscular route
• Advocate PCA, intrathecal, and epidural routes of administration when appropriate
• Modify pain control measures on the basis of the patient’s response to treatment
• Prevent and/or manage medication side effects
• Notify prescribing provider if pain control measures are unsuccessful
• Provide accurate information to family members or caregivers about the patient’s pain experience with the patient’s permission

See the following box for a summarized list of interventions for chronic pain management.

**Chronic Pain Management**[8]

• Explore the patient’s knowledge and beliefs about pain, including cultural influences
• Determine the pain experience on quality of life (e.g., sleep, appetite, activity, cognition, mood, relationships, job performance, and role responsibilities)
• Evaluate the effectiveness of past pain control measures with the patient
• Question the patient regarding the level of pain that allows a state of comfort and appropriate functioning and attempt to keep pain at or lower than identified level
• Control environmental factors that may influence the patient’s pain experience
• Ensure that the patient receives prompt analgesic care before the pain becomes severe or before activities that are anticipated to be pain-inducing
• Select and implement intervention options tailored to the patient’s risks, benefits, and preferences (e.g., pharmacological, nonpharmacological, interpersonal) to facilitate pain relief, as appropriate
• Instruct the patient and family about principles of pain management
• Encourage the patient to monitor own pain and to use self-management approaches
• Encourage appropriate use of nonpharmacological techniques (e.g., biofeedback, TENS, hypnosis, relaxation, guided imagery, music therapy, distraction, play therapy, activity therapy, acupressure, heat and cold application, and massage) and pharmacological options as pain control measures
• Avoid use of analgesics that may have adverse effects on older adults
• Collaborate with the patient, family, and other health professionals to select and implement pain control measures
• Prevent or manage side effects
• Evaluate the effectiveness of pain control measures through ongoing monitoring of the pain experience
• Watch for signs of depression (e.g., sleeplessness, not eating, flat affect, statements of depression, or suicidal ideation)
• Watch for signs of anxiety or fear (e.g., irritability, tension, worry, or fear of movement)
• Modify pain control measures on the basis of the patient’s response to treatment
• Incorporate the family in the pain relief modality, when possible
• Utilize a multidisciplinary approach to pain management, when appropriate
• Consider referrals for the patient and family to support groups and other resources, as appropriate
• Evaluate patient satisfaction with pain management at specified intervals
• Evaluate barriers to adherence with past pain management care plans

Implementing Pharmacological Interventions

Patients should be involved and engaged in their plan of care to treat pain. By demonstrating empathy and collaborating with patients and the interdisciplinary team, it is more likely the treatment plan will be effective based on the patient’s goals.

When administering analgesic medication, holistic nursing care is important. Begin by considering the patient’s goals for pain relief and ask if they have been met effectively by previously administered medications. If they have not been met, it may be necessary to advocate for additional or alternative medication with the health care provider. It is also important to consider if the patient is experiencing any side effects that may impact the patient’s desire to take additional pain medication.

When administering medications that have been ordered on an "as-needed" basis, it is vital for the nurse to verify the amount of medication the patient received in the past 24 hours and if any dosage limits have been met to ensure patient safety.

Prior to administration, consider the best route of administration for this patient at this particular time. For example, if the patient is nauseated and vomiting, then an oral route may not be effective. On the other hand, if a patient’s pain has improved when receiving intravenous medications during the recovery process, it may be possible for the patient to begin taking oral pain medications in preparation for discharge home. Keep the WHO ladder in mind when selecting medications to reach patient goals while also avoiding potential adverse effects when possible.

When preparing opioid medications, it is important to remember that these medications are controlled substances with special regulations regarding storage, count auditing, and disposal/wasting of medication. Follow agency policy regarding these issues. It is also important to assess the patient’s level of sedation and respiratory status before administering additional doses of opioids and withhold the medication if the patient is oversedated or their respiratory rate is less than 12/minute. However, when providing pain management during end-of-life care, these parameters no longer apply because the emphasis is on providing comfort according to the patient’s preferences. Read more about end-of-life care in the “Grief and Loss” chapter.

Evaluation

It is vital for the nurse to regularly evaluate if the established interventions are effectively meeting the pain management and function goals established collaboratively with the patient. Additionally, when administering analgesics, the patient should be reassessed in an hour (or other time frame based on the onset and peak of the medication) to determine if the medication was effective. If interventions are not effective, then follow-up interventions are required, which may include contacting the health care provider.
For patients living with chronic pain, it can be helpful for them or their caregiver to maintain a pain journal. In the journal they can document activities that precipitated pain, medications taken to manage the pain, and whether these medications were effective in helping them to meet their functional goals. This journal is shared with the health care provider during follow-up visits to enhance the treatment plan. [9]

The nurse must continually monitor for potential adverse effects of pain medications. For example, if a patient is receiving acetaminophen daily for chronic osteoarthritis pain, signs of liver dysfunction, such as jaundice and elevated liver function bloodwork, should be monitored. For older adults receiving NSAIDs, it is important to watch for early signs of gastrointestinal bleeding, such as melena. Patients receiving opioids should be continually monitored for oversedation, respiratory depression, constipation, nausea and vomiting, urinary retention, and pruritus. Side effects should be reported to the health care provider and orders received for treatment.

1. “238074231_2485ed053b_o” by Erik Ogan is licensed under CC BY-SA 2.0

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