SULTAN QABOOS UNIVERSITY HOSPITAL
NURSING DIRECTORATE

4. PAIN - 5th VITAL SIGN

Standard Statement: Patient's pain needs (discomfort, distress or suffering) are adequately addressed and effectively managed through assessment, reassessment ,intervention and patient advocacy.

STRUCTURE	PROCESS	OUTCOME
• Patient • Family • Ward Nurse • Pain Management Nurse	**ASSESSMENT:** • Assess patient for discomfort, signs of distress or suffering from time of admission and throughout the patient's hospital stay. • Obtain a pain history including past medical history, medication, habits, family history and psychosocial history. • Accept and respect self report • Ask patient how he/she feels for (adults), ask parents if patient is a child. • Has anything changed recently? • Any pain, burning, SOB, chest pains, change in bowel or bladder habits or cough • Any discharge from any orifice. • Depression, sadness or change in appetite	The patient's needs will be identified and met satisfactorily.

STRUCTURE	PROCESS	OUTCOME
• Patient • Family • Ward Nurse • Pain Management Nurse	PRE /POST OPERATIVE ASSESSMENT & PATIENT EDUCATION: • Establish a caring relationship with patients and or families. • Review pain history • Educate the patient about pain assessment (e.g., methods, frequency) and pharmacologic management strategies. • Explore concerns/dispel misconceptions about use of pain medications, side effects and addiction. • Collaborate with patient based on condition e.g., surgery or medical condition. • Encourage patient/ parent (children) to select appropriate pain measurement tool. • Educate patient / parent (children) about their responsibilities in pain management e.g., providing factual report of pain, preventing or halting pain before it has become well established. • Document the patient's preferred pain assessment tool and the goals for pain control (pain score).	The patient will: • Understand the operative process and the management required. • Verbalized her/his limited knowledge on reporting of pain • Reassured that his/her pain will be managed accordingly. • Learn about pain medication ;its effect and side effects.

STRUCTURE	PROCESS	OUTCOME
• Patient • Family • Ward Nurse • Pain Management Nurse	• Measure pain at rest and during activity (e.g., moving, deep breathing or coughing). ○ Assess pain frequently during the immediate postoperative period at regular intervals, consistent with condition and pain severity (every 2 hours while awake or 1 hour 1 day after surgery) ○ With each new report of pain ○ Suitable interval after each use of analgesics intervention (e.g., 30 minutes after parenteral drug therapy, and 1 hour after oral analgesics. ○ Increase frequency of assessment for changing interventions or inadequate pain control. ○ Immediately evaluate instances of unexpected intense pain, particularly if sudden or associated with evidence of potential complications. ○ Give special consideration to the needs of special needs populations and be aware of potential barriers to effective communication.	**The nurse will :** • Be able to identify the changing needs(Pain) of the patient and intervene timely • Teach the patient and family about pain and their role in controlling patient's pain.

STRUCTURE	PROCESS	OUTCOME

• Patient
• Family
• Ward Nurse
	MEASUREMENT OF PAIN:
	
	• Ask patient / child for all this information about pain:
	  ○ location(exactly where is the pain, point)
	  ○ Intensity, determine strength, power or force of pain, using numeric or face picture scale.
	  ○ Quality, features of characteristics that distinguish pain as searing, dull, throbbing, sharp, burning, etc.
	  ○ Pattern, how pain changes and timing of pain as continuous, steady, intermittent , transient
	  ○ Pain that that occurs over 6 months period or longer, varies in intensity and mat serve no useful function.
	• Introduce pain assessment tool(s) to patient or child and family.
	  ○ patient self report of pain
	  ○ rating scales e.g., 0-10 (verbal or word) or visual (VAS) description of pain e.g., the Face Pain Scale for adult and children and Wong Bakers Faces for children.
		The patient will:
		• Understand the process of measuring their pain (Charts/Tool) and its importance for promoting a pain free state.
		• Learn how to describe their pain
		
		The nurse will:
		• Promote comfort and alleviate pain.
		• Explain the importance of patients participation in his/her care e.g.; reporting of pain

STRUCTURE	PROCESS	OUTCOME

• Patient
• Ward Nurse
	REASSESSMENT OF PAIN
	• Frequency of Reassessment :
	  ○ within 30 minutes of Parenteral drug administration
	  ○ within one hour of oral drug administration
	  ○ with each report of new or changed pain
		The patient will:
		• Achieve a pain free status.

• Nurse	DOCUMENTATION: • Admission assessment and re assessment should be indicated in the Admission and Reassessment Checklist (Use Manual Form if not available electronically. • All pain observations from admission and entire period of hospitalization must be documented in the EPR. • Patient's response to medication and other related pain management must be documented in a timely manner in the EPR. • All manual observation charts (Wong Bakers/ FLACC) must be scanned and upload in the EPR. • Health education as to pain and it's management must be documented	The nurse maintained a complete, accurate and timely record of patients pain, the treatment regime and patients response.