



# Pain Management Procedure

Procedure Number

WCDHB-PN-0014

Version Nos:

3

## 1. Purpose

This Procedure is performed as a means of:

- maximising patients/clients/residents right to have their pain management needs identified and effectively managed;
- assuring that patients/clients/residents are assessed for pain using a systematic approach that reflects current standards of care for pain management;
- assuring patients/clients/residents receive pain control that is acceptable to them based on current standards of care for pain management.

## 2. Application

This Procedure is to be followed by all nursing staff throughout the West Coast District Health Board (WCDHB).

## 3. Definitions

For the purposes of this Procedure:

*Pain management* is taken to mean a process that facilitates healing, promotes comfort and a feeling of well-being, improves quality of life, that may shorten the length of stay by increasing mobility, nutritional intake and rest.

## 4. Staff Authorised To Perform Procedure/Responsibilities

This Procedure shall be performed by a:

- i) registered nurse; or
- ii) enrolled nurse; or
- iii) student nurse (under supervision).

## 5. Resources Required

This Procedure requires:

- i) Patient Medical Record
- ii) Pain Management Medication

## 6. Process

1.00 Pain should be managed to a level that is acceptable to the patient/client/resident.

1.01 Upon admission, patients/clients/residents verbalising or otherwise exhibiting pain will have an assessment completed within 24 hours of admission.



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- 1.02 The assessment for pain is to include assessments for:
- allergies and previous adverse reactions to pain medications prior to initial dose of analgesic medications;
  - presence, location, and characteristics of pain;
  - identification of the intensity of pain when present using an appropriate pain assessment scale based upon patient chronological or developmental age;
  - physiologic signs of pain:
    - tachycardia;
    - tachypnea;
    - diaphoresis;
    - muscle tension;
    - elevated BP;
    - pallor;
    - dilated pupils;
    - nausea;
  - monitoring for behavioural signs of pain:
    - frowning;
    - gritting teeth;
    - clutching/rubbing affected part;
    - grimacing;
    - hostility;
    - fetal position;
    - clinched fists;
    - restlessness;
    - increased muscle tension;
    - crying/moaning;
    - loss of appetite;
    - depression.
- 1.03 After the initial assessment, patients/clients/residents experiencing pain are to have their pain level assessed by nursing staff at least once every shift and after each pain intervention. However, patients/clients/residents having acute or severe pain symptoms may require more frequent pain assessment and intervention.
- 1.04 Nursing staff completing a pain assessment are to report their findings to the patient's/client's/resident's doctor as well as any history of allergies, or previous adverse reactions to prescribed medications.
- 1.05 Nursing staff will administer analgesics as prescribed to prevent severe pain from reoccurring and prophylactically prior to activities associated with discomfort.
- 1.06 Nursing staff will document the effectiveness of analgesic administration and notify the patient's/client's/resident's doctor of ineffective pain management following administration of the prescribed analgesic.
- 1.07 Patients/clients/residents activity is to be planned around peak time of pain management.



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1.08 If appropriate, the use of non-pharmacological interventions is to be considered:

- heat/cold;
- humor;
- position change;
- back massage;
- relaxation;
- music/T.V.;
- imagery;
- environmental change;

and their effectiveness documented.

1.09 Nursing staff are to discuss the following with the patient/client/resident and their if appropriate, family/whanau/caregiver:

- cause of pain and expected duration;
- presence, location and characteristics of pain;
- pain medication action and expected effects;
- need to request PRN medication at onset of pain;
- need to notify staff of increasing discomfort or dissatisfaction with pain management.

## 7. Precautions And Considerations

- ➔ Pain should be managed to a level that is acceptable to the patient/client/resident.
- ➔ Assessment for pain is to be comprehensive
- ➔ If appropriate, the use of non-pharmacological interventions is to be considered

## 8. References

US Department of Health and Human Services; Agency For Health Care Policy and Research (1992) Acute Pain Management; Operative or Medical Procedures

Bosek, M. (1993) The Ethics Of Pain Management. Med Surg Nursing, 2(3), 218-220

Christoph, S. (1991). Pain Assessment. Critical Care Nursing Clinics of North America, 3(1)

## 9. Related Documents

WCDHB Medication Policy

WCDHB Administration Of Medication Procedure

WCDHB Administration and Medication Of Controlled Medication Procedure

<b>Revision History</b>	<b>Version:</b>	3
	<b>Developed By:</b>	QI Co-Ordinator
	<b>Authorised By:</b>	Director of Nursing
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