



Understanding and Managing Pain

One (1.0) Contact Hour

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Purpose and Learning Objectives

The purpose of this course is to provide nurses with an overview of pain assessment and strategies for managing pain.

This course will cover material associated with assessment and management of pain with adult and pediatric patients. Pain in the neonate is outside the scope of this course.

After successful completion of this course, you will be able to:

- Identify basic physiology of pain.
- Describe appropriate components of pain assessment.
- Describe developmental and individual patient considerations in assessing pain.
- Identify pharmacologic and non-pharmacologic interventions to alleviate pain.
- Discuss considerations with using opioids.

Introduction

Pain can be a common experience for patients in the hospital setting. It is integral to the role of a nurse to effectively assess and manage the perception of pain for patients. Nurses require both the knowledge and skills to appropriately plan and provide interventions for pain.

The Centers for Disease Control and Prevention (CDC) conducted the National Health Interview Survey in 2010. 30% of respondents over the age of 18 stated they had migraines, back pain, neck pain, or facial pain within the three months prior to the survey (CDC, 2012). It is also estimated that 100 million people in the U.S. suffer from chronic pain, resulting in approximately \$560-\$635 billion annually in healthcare costs (Institute of Medicine, 2011).

Pain Defined

Pain is defined as “an unpleasant sensation caused by noxious stimulation of the sensory nerve

endings. It is a subjective feeling and an individual response to the cause. Pain is a cardinal symptom of inflammation and is valuable in the diagnosis of many disorders and conditions. It may be mild or severe, chronic or acute, lancinating, burning, dull or sharp, precisely or poorly localized, or referred. Experiencing pain is influenced by physical, mental, biochemical, psychological, physiologic, social, cultural, and emotional factors” (Mosby’s Medical Dictionary, 2012).

Process of Pain

Nociception is the process where information about tissue damage is conveyed to the central nervous system through sensory receptors (nociceptors). There can be pain without nociception (such as phantom limb pain), or nociception without pain. Pain occurs through five activities:

Transduction: Energy is converted from a noxious stimulus (thermal, mechanical, or chemical) into electrical energy (nerve impulses) by nociceptors

Conduction: The neural signals are conducted from the axons to the cell bodies in the spinal cord

Transmission: The transmission of the neural signals from the transduction site to the spinal cord and brain; activation of neurotransmitters occurs

Perception: In higher structures, the arriving signals are appreciated as pain

Modulation: Occurs at the spinal cord level; descending input from the brain influences (modulates) nociceptive transmission

(Fein, 2012; Interagency Pain Research Coordinating Committee [IPRCC], 2016)

Types of Pain

Pain is categorized as nociceptive or neuropathic, depending on the underlying pathophysiology.

Nociceptive Pain

Nociceptive pain is caused by the ongoing activation of nociceptors responding to noxious stimuli (such as inflammation, injury, or disease). Visceral pain arises from visceral organs, while pain coming from tissues is called somatic pain. In nociceptive pain, the central nervous system is functioning appropriately. There is a close association between the intensity of the stimulus and the perception of pain, indicating real or potential tissue damage.

Neuropathic Pain

Neuropathic or pathologic pain is caused by abnormal signals in the central or peripheral nervous systems, demonstrating injury or impairment. Causes of neuropathic pain may include inflammation, trauma, infections, tumors, metabolic diseases, toxins, or neurological disease (Cohen & Mao, 2014; IPRCC, 2016).

Types of Pain

Type of Pain	Location	Quality of Pain	Localization	Sources	Examples
Nociceptive–somatic	Skin, tissue, muscles, tendons, joints, bones	Burning, sharp, dull, aching, cramping	Well localized to diffuse and radiating	Traumatic events, strain, injury, ischemia, inflammation, dermatological	Surgery, burns, cuts, contusions, arthritis, tendonitis
Nociceptive-visceral	Visceral organs	Sharp stabbing or deep aching	Well or poorly localized	Ischemia, inflammation, organ distension, muscle spasm	Appendicitis, pancreatitis, gastric ulcer, bladder distension
Neuropathic	Peripheral	Sensitivity, burning, aching, shock, sensations, shooting, cramping, throbbing, numbness, tingling	Diffuse; can be difficult to determine	Peripheral nerve damage, lesions, demyelination, trauma, compressive, metabolic disorders, ischemia, circulatory impairment, CNS disease	Diabetic neuropathy, neuralgia, carpal tunnel syndrome, fibromyalgia, phantom limb pain, post-stroke, multiple sclerosis

(Alexander, 2013; Cohen & Mao, 2014; IPRCC, 2016).

Test Yourself

Which type of pain arises from organs?

Neuropathic

Visceral - **Correct!**

Somatic

Acute versus Chronic Pain

Pain can be classified as acute or chronic. Acute pain is complex, and is described as an unpleasant experience with an identifiable precipitating cause. Acute pain generally has defined pathology, and can resolve with healing of the underlying injury. Acute pain can also be seen as a reflexive and protective response.

Chronic pain is described as pain that persists at least three months beyond the expected course of an acute injury or illness. Chronic pain is considered a biopsychosocial condition which can also disrupt activities of daily living and sleep, and has no protective purpose (Alexander, 2013; IPRCC, 2016).

Acute vs. Chronic Pain

Type of Pain	Description
Acute	<ul style="list-style-type: none">• Pain usually associated with degree of tissue damage, which decreases with healing of the injury• Is a result of activation of nociceptors and/or neurons• Often associated with the autonomic nervous system and other protective responses (e.g. guarding behaviors)
Chronic	<ul style="list-style-type: none">• Difficult to identify underlying pathology and explain the presence and/or extent of the pain• Perpetuated by factors apart from the cause• Pain can be continuous or intermittent, with or without acute exacerbations• Symptoms of autonomic nervous system hyperactivity less common• Depressed mood, irritability, changes in effect, social withdrawal, fatigue, changes in activities of daily living, disrupted social relationships• Loss can be a common experience, such as loss of activity or identity; grief may occur

(Alexander, 2013; IPRCC, 2016).

Continuum of Pain

Pain occurs along a continuum, and acute pain can progress into chronic pain based on a variety of factors. Chronic pain is very complex, and includes individualized risk factors. Appropriate assessments and use of evidence-based practice and coordinated care are essential for prevention and treatment of pain. Holistic care, including cultural and biopsychosocial considerations, is essential with pain management (IPRCC, 2016).

Pain Assessment

Pain is often referred to as the “fifth vital sign,” and should be assessed regularly and frequently. Pain is individualized and subjective; therefore, the patient’s self-report of pain is the most reliable gauge of the experience. If a patient is unable to communicate, the family or caregiver can provide input. Use of interpreter services may be necessary. Components of pain assessment include: a) history and physical assessment; b) functional assessment; c) psychosocial assessment; and d) multidimensional assessment.

Pain assessment is:

- Asking and believing the patient
- Assessing the patient
- Assessing the cause of the pain
- Communicating the findings
- Assessing changes in behavior for potential pain

Pain assessment is NOT:

- Relying on changes in vital signs

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- Deciding that a patient doesn't look uncomfortable
- Knowing how much a procedure or disease "should" hurt
- Assuming a patient will tell you when they are in pain

History and Physical Assessment

The assessment should include physical examination and the systems in relation to pain evaluation. Areas of focus should include site of the pain, musculoskeletal system, and neurological system.

Other components of history and physical assessment include:

- Patient's self-report of pain
- Patient's behaviors and gestures that indicate pain (e.g. crying, guarding, etc.)
- Specific aspects of pain: onset and duration, location, quality of pain (as described by patient), intensity, aggravating and alleviating factors
- Medication history
- Disease or injury history
- History of pain relief measures, including medications, supplements, exercise, massage, complementary and alternative therapies

(Anderson, 2013; American Pain Society, 2007; IPRCC, 2016 Oregon Pain Commission, 2012)

Functional and Psychosocial Assessment

Components of the functional and psychosocial assessment include:

- Reports of patient's prior level of function
- Observation of patient's behaviors while performing functional tasks
- Patient or family's report of impact of pain on activities of daily living, including work, self-care, exercise, and leisure
- Patient's goal for pain management and level of function
- Patient or family's report of impact of pain on quality of life
- Cultural and developmental considerations
- History of pain in relation to depression, abuse, psychopathology, chemical or alcohol use
- Impact of pain on patient's cognitive abilities
- Special considerations of the geriatric population: patients may under-report pain (unless asked directly), communication about pain may be hindered by visual or hearing impairment, and dementia behaviors may increase with poor pain management

(Anderson, 2013; CPM Resource Center, 2012a; IPRCC, 2016 Oregon Pain Commission, 2012)

Test Yourself

Components of history that are needed as part of assessment include:

Medical history

History of medications

History of substance abuse

All of the above - **Correct!**

Multidimensional Assessment

Many tools are available for an in-depth, multidimensional pain assessment. This is particularly important with patients that have chronic pain, mixed pain (both acute and chronic), or complex situations (such as multiple disease processes). Common examples of these tools include:

- **Brief Pain Inventory:** Provides patient input in describing pain and effects, including psychosocial components. Can be viewed at <http://medicine.iupui.edu/RHEU/Physicians/bpif.pdf>
- **McGill Pain Questionnaire:** Patients can use descriptors for their pain, which provides information about the experience and intensity. Can be viewed at <http://www.chcr.brown.edu/pcoc/MCGILLPAINQUEST.PDF>

Common Pain Scales

There are a variety of pain scales used for pain assessment, for patients from neonates through advanced ages. The three most common scales recommended for use with pain assessment are:

- The numeric scale
- The Wong-Baker scale (also known as the FACES scale)
- The FLACC scale

An alternative scale for non-verbal adults is the Checklist of Nonverbal Pain Indicators (CNPI) (Health Care Association of New Jersey, 2011).

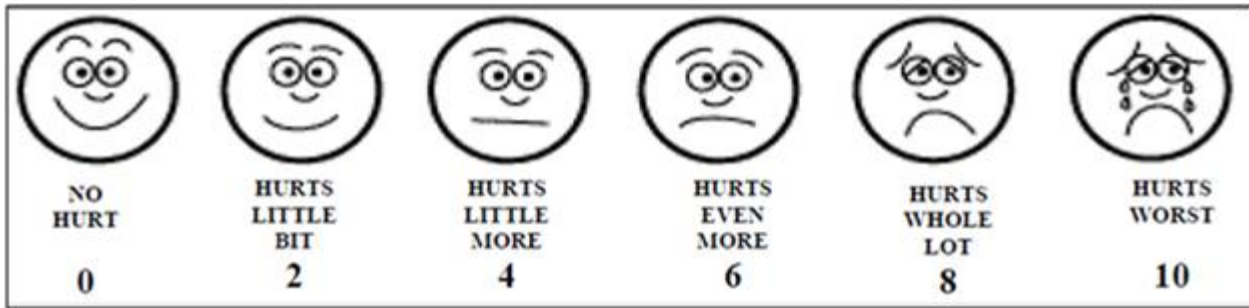
The Numeric Scale

The numeric scale is the most commonly used pain scale with adult patients, rating pain on a scale of 0-10. Many nurses ask for a verbal response to the question. Use of this scale with the visual analog can provide a more accurate response. This scale is appropriate with patients aged nine and older that are able to use numbers to rate their pain intensity (Health Care Association of New Jersey, 2011).

NUMERIC SCALE: Choose a number from 0 to 10 that best describes the level of pain.										
NO PAIN	MILD PAIN, ANNOYING Pain is present but does not limit activity.	NAGGING PAIN, UNCOMFORTABLE, TROUBLESOME Can do most activities with rest periods.	MISERABLE, DISTRESSING Unable to do some activities because of pain.	INTENSE, DREADFUL, HORRIBLE Unable to do most activities because of pain.	WORST PAIN POSSIBLE, UNBEARABLE Unable to do any activities because of pain.					
0	1	2	3	4	5	6	7	8	9	10

Wong-Baker Scale

The Wong-Baker FACES Scale uses drawn faces for patients to express their level of pain. The faces are associated with numbers on a scale ranging from 0 to 10. This scale is most commonly used with children, and is appropriate to use with patients ages three and older. Adults who have developmental or communication challenges may benefit from using this scale (Health Care Association of New Jersey, 2011).



FLACC Scale

FLACC is the acronym for Face, Legs, Activity, Cry, and Consolability. This scale is based on observed behaviors, and is most commonly used with pediatric patients less than three years of age. The behaviors that are described are associated with a number; each component is totaled for a number ranging from 0 to 10. This scale is also appropriate with patients who have developmental delays or are non-verbal (Health Care Association of New Jersey, 2011).

FACE	0 No particular expression of smile.	1 Occasional grimace or frown, withdrawn, disinterested.	2 Frequent to constant frown, clenched jaw, quivering chin.
LEGS	0 Normal Position or relaxed.	1 Uneasy, restless, tense.	2 Kicking, or legs drawn up.
ACTIVITY	0 Lying quietly, normal position, moves easily.	1 Squirming, shifting back and forth, tense.	2 Arched, rigid, or jerking.
CRY	0 No crying (awake or asleep).	1 Moans or whimpers, occasional complaint	2 Crying steadily, screams or sobs, frequent complaints.
CONSOLABILITY	0 Content, relaxed.	1 Reassured by occasional touching, hugging, or "talking to." Distractible.	2 Difficult to console or comfort.

Test Yourself

The most appropriate scale to use with a seven-year-old patient is:

Numeric scale

FLACC scale

Wong-Baker FACES scale - **Correct!**

Checklist of Nonverbal Pain Indicators (CNPI)

The CNPI is used for adults who are nonverbal; it is also designed to measure pain behaviors in cognitively impaired older adults.

Each item is scored both with movement and at rest. Score is "0" if the behavior was not observed. Score is "1" if the behavior occurred even briefly. The scores are subtotaled for the movement and at rest columns, and added together for a total score. There are no clear cut-off scores to indicate severity of pain. Instead, the presence of any of these behaviors may be indicative of pain and warrants further investigation, treatment and/or monitoring (Lichtner et al., 2014).

Behavior	With Movement	At Rest
1. Vocal complaints: nonverbal (Sighs, gasps, moans, groans, cries)		
2. Facial grimaces/winces (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)		
3. Bracing (Clutching or holding onto furniture, equipment, or affected area during movement)		
4. Restlessness (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)		
5. Rubbing (Massaging affected area)		
6. Vocal complaints: verbal (Words expressing discomfort or pain [e.g., 'ouch', 'that hurts']; cursing during movement; exclamations of protest [e.g., 'stop', 'that's enough!])		
Subtotal Scores		
Total Score		

Pain Management

Pain management refers to the appropriate treatment and interventions developed in relation to pain assessment, and should be developed in collaboration with the patient and family. Strategies are developed based on past experiences with effective and non-effective treatments to meet the patient's goal for pain management. Considerations include type of pain, disease processes, risks, and benefits of treatment modalities. Pain management strategies include pharmacological and non-pharmacological approaches (Health Care Association of New Jersey, 2011; IPRCC, 2016).

Non-Pharmacological Treatment

There are a variety of approaches for decreasing pain in adult and pediatric patients that are non-pharmacological. These types of strategies are often over-looked, but can be effective for alleviating pain when used either alone or in combination with other non-pharmacological or pharmacological measures.

Non-Pharmacological Treatment

Non-pharmacological interventions may include:

- Heat or cold (as appropriate)
- Massage
- Therapeutic touch
- Decreasing environmental stimuli (e.g. sound, lighting, temperature)
- Range of motion or physical therapy
- Repositioning
- Immobilization
- Relaxation techniques and imagery
- Distraction
- Psychotherapy or cognitive behavioral therapy
- Biofeedback
- Music therapy
- Aromatherapy
- Acupressure or acupuncture
- Transcutaneous electrical stimulus (TENS)

(City of Hope National Medical Center, 2011; CPM Resource Center, 2012a, 2012b, 2012c, 2012d).

WHO Analgesic Ladder

One tool that was developed by the World Health Organization (WHO) in 1986 is the WHO analgesic ladder. This framework was originally developed to assist physicians in treatment choices for cancer pain. This tool continues to be validated, and used for not just cancer pain, but other forms of acute and chronic pain (CPM Resource Center, 2012a; CPM Resource Center, 2012c; Schaffer, 2010).

The analgesic ladder is used as a guideline, and is described as follows:

Step 1: Mild pain (e.g. rating of 0-3 on a scale of 0-10): Uses non-opioid and/or a nonsteroidal anti-inflammatory drug (NSAID), and other non-pharmacological strategies to improve quality of relief.

Step 2: Moderate pain (e.g. rating of 4-6): Continue with medications and methods described in step 1, plus add a mild opioid.

Step 3: Severe pain (e.g. rating of 7-10): Along with medications and strategies described in steps 1 and 2, add a more potent opioid (e.g., morphine, hydromorphone, fentanyl).

(CPM Resource Center, 2012a; CPM Resource Center, 2012c; Schaffer, 2010).

Pharmacological Treatments

The use of medications to treat pain can be complex. Multiple factors must be considered including age, current medications, patient medical and substance use history, type of pain (such as neuropathic versus nociceptive), etc. Pharmacological treatments include:

- **Analgesic:** Acetaminophen (Tylenol®) is a common analgesic used for mild pain, or in a combination with opioids for moderate pain. There must be caution taken in the amount of acetaminophen used per day, which can result in hepatic toxicity.
- **Non-steroidal anti-inflammatories (NSAIDs):** Common examples include salicylates, ibuprofen (Advil®), naproxen (Aleve®), and ketorolac (Toradol®). These are used to reduce inflammation which can decrease pain. NSAIDs can be used for mild pain, or in combination with opioids for moderate pain. Caution is needed with dosages for pediatric and elderly patients, and is contraindicated in patients with hepatic or renal impairment, bleeding disorders, or gastrointestinal ulcers.
- **Tricyclic antidepressants (TCAs):** Examples include amitriptyline (Elavil®), nortriptyline (Aventyl®), and desipramine (Norpramin®). TCAs can be effective in treating neuropathic pain, and can provide a mild analgesic effect. Caution should be taken with pediatric and elderly patients.
- **Selective serotonin reuptake inhibitors (SSRIs):** Common examples include fluoxetine (Prozac®), paroxetine (Paxil®), serotonin, and sertraline (Zoloft®). SSRIs can be used as adjunct therapy for depression and treating neuropathic pain. Caution is required with pediatric and elderly patients, as there is a risk of suicidal thoughts.
- **Anticonvulsants:** Examples include carbamazepine (Tegretol®), gabapentin (Neurontin®), and pregabalin (Lyrica®). Anticonvulsants can provide sedation and a graded analgesic effect, and are also used for treating neuropathic pain.
- **Topical agents:** Common examples include creams that have analgesic or local anesthetic agents. Topical agents may be used with neuropathies or arthritis.

- **Anesthetics:** Anesthetics can be used for epidurals or nerve blocks to assist with acute or chronic pain. These are temporary, and may be effective up to three or four months. Risks and benefits must be evaluated prior to performing a block.
- **Opioids:** Common examples of mild opioids include codeine, oxycodone, and hydrocodone. Common examples of more potent opioids are morphine, fentanyl, and hydromorphone, used for moderate to severe pain. Opioids can be used with both acute and chronic pain.

(City of Hope National Medical Center, 2011; CPM Resource Center, 2012a, 2012b, 2012c, 2012d).

Test Yourself

Opioids should be considered in addition to other treatment strategies with patients suffering from moderate pain.

True - **Correct!**

False

Opioid Considerations

Opioids can be part of a treatment plan individualized to the patient. Opioids should not be used as a first line treatment for neuropathic pain, but may be appropriate with the use of other therapies. A trial of opioids can be implemented with patients following non-pharmacological methods, but may be started earlier with severe pain. Risks and benefits of using opioids should be discussed with the patient and family. Considerations for bowel management and prevention of nausea and vomiting are required (CPM Resource Center, 2012a, 2012b, 2012c, 2012d; IPRCC, 2016).

Medications should be started at lower doses in short-acting form, and titrated up for pain control that correlates with the patient's pain goals. Other considerations include if a patient is opioid naïve or opioid tolerant. A patient who is opioid naïve occurs with patients not already taking opioids, as tolerance can develop after several days. A patient who is opioid tolerant is seen with patients regularly taking opioids, generally associated with chronic pain. Use of recreational substances should also be considered. Opioid tolerant patients will require higher doses to achieve the desired effect (IPRCC, 2016; Shands, 2012).

Under-Treatment of Pain

There are still many myths and misbeliefs about the use of opioids and addiction which can lead to under-treatment of pain. This is particularly true of elderly patients, and those suffering from chronic pain. Unrelieved pain can lead to physical and psychological disruptions, including hormone fluctuation, electrolyte and glucose imbalance, hypertension, tachycardia, increased oxygen consumption, impaired intake and output, fatigue, depressed immune response, reduced cognitive function, insomnia, anxiety, depression, hopelessness, and thoughts of suicide (CPM Resource Center, 2012a, 2012b, 2012c, 2012d; IPRCC, 2016).

Fear of Addiction

There has been mounting attention to problems of addiction related to over-prescribing opioids, particularly for patients with chronic pain. With this increased fear, there is also a higher risk of undertreating pain. There is genuine concern surrounding addiction, but studies discussed in the National Pain Strategy (IPRCC, 2016) state that 74-96% of chronic pain patients who take opioids use their prescriptions appropriately, without addiction. Screening of patients for risk factors, and use of multiple modalities and strategies for treating chronic pain are important for pain management. Even high risk patients still require appropriate treatment, and will require more frequent, ongoing assessment and monitoring (IPRCC, 2016; Sehgal, Manchikanti, & Smith, 2012).

Definitions Related to Addiction

Misuse is described as the use of a medication for reasons other than prescribed, or for nonmedical usage. Misuse can be willful or unintentional, and is the use of a substance in a manner not consistent with legal or medical guidelines. Examples include altering dosages or sharing medicines, which has harmful or potentially harmful consequences. It does not refer to use for mind-altering purposes (Sehgal, Manchikanti, & Smith, 2012).

Abuse is known as the misuse of a substance with consequences, including the use of a substance to modify or control mood or state of mind in a manner that is illegal or harmful to oneself or others. Abuse has potentially harmful consequences, such as accidents, injuries, blackouts, legal problems, and sexual behavior that increases the transmission risk of infection, diseases, and viruses (Sehgal, Manchikanti, & Smith, 2012).

Diversion is the intentional relocation of a controlled substance from legal and legitimate distribution and dispensing channels into illegal paths or obtaining a controlled substance by an illegal method (Sehgal, Manchikanti, & Smith, 2012).

Definitions Related to Addiction, con't

Tolerance is known as a state of adaptation where exposure to a drug produces a decrease of one or more effects over time (Sehgal, Manchikanti, & Smith, 2012).

Physical dependence is a state of adaptation demonstrated by a withdrawal syndrome specific to a particular drug, that can be produced by abrupt cessation, a rapid reduction in dose, decreased blood level of the drug, and/or administration of the drug antagonist (Sehgal, Manchikanti, & Smith, 2012).

Addiction is defined as a primary and chronic neurobiological disease, that has genetic, psychosocial, and environmental factors influencing its development and manifestations. Addiction is characterized by behaviors such as impaired control over drug use, compulsive use, craving, and continued use despite harm (Sehgal, Manchikanti, & Smith, 2012).

Aberrant drug-related behavior occurs outside the boundaries of the agreed-on treatment plan; a treatment plan should be established as early as possible in the doctor-patient relationship, with frequent follow up throughout the course of treatment (Sehgal, Manchikanti, & Smith, 2012).

Risk Factors for Addiction

There are risk factors which have been identified, placing patients at a higher risk for misuse and addiction. Single risk factors by themselves do not increase the risk, but a patient has a risk factor in three categories, they are considered high risk. The risk factors include:

- Demographics:
 - Young adults
 - Male gender
 - Caucasian
- Pain severity:
 - Reports of higher levels of pain
 - Multiple pain reports
 - More ADL or functional limitations related to pain
 - Low pain tolerance
- Psychosocial factors:
 - History of mood disorder or psychological problems
 - History of psychosocial stressors
 - Personal or family history of substance use disorders, such as history of alcohol and illicit drug abuse

- Medication-related factors:
 - Self-reported craving for the medication
 - Treatment with daily high doses of opioids
 - Use of short-acting opioids
- Genetics:
 - Genetic variations are currently being studied
 - There may be functional changes in proteins which may contribute to dependency

(Sehgal, Manchikanti, & Smith, 2012)

Principles of Pain Management

As nurses, it is also important to remember that we have an ethical obligation to appropriately assess and treat patients' pain. Unfortunately, there are barriers to this, including underestimating the severity of a patient's pain, disregarding or disbelieving self-reports of pain, beliefs of "drug-seeking" behavior, and fear of causing addiction or oversedation with patients (IPRCC, 2016).

ABCDE Method

Useful principles of pain management can be remembered with the "ABCDE method" as follows:

A: Ask about pain regularly

B: Believe the patient's and/or family's reports of pain

C: Choose appropriate pain approaches and treatment options

D: Deliver interventions in a coordinated and timely fashion

E: Empower patients and their families

(Denny & Guido, 2012; Health Care Association of New Jersey, 2011)

Nursing Responsibilities

Pain management is a vital component of patient care, and can be complex. It is important to individualize plan of care for each patient. Nursing responsibilities include:

- **Pain assessment:** The nurse must adequately and completely assess the patient's pain
- **Pain rating:** The nurse will appropriately identify a pain rating scale matched to the patient's needs
- **Patient and family involvement in pain management:** The nurse must include the patient and family in development of the pain management plan of care
- **Physician communication:** The nurse will notify the physician of any new pain, and/or pain that is not managed adequately
- **Medication administration:** The nurse must administer medication in an appropriate and safe manner
- **Patient and family involvement in non-pharmacological pain interventions:** The nurse will involve the patient and family, and provide appropriate instructions
- **Patient and family education:** The nurse will instruct the patient and family on the correct administration and management of medications and side effects, and provide them with pain management resources
- **Involvement of ancillary services:** The nurse will involve ancillary services in consultation for planning and implementation of pain management strategies
- **Interdisciplinary communications:** The nurse must communicate assessment, interventions, and pain management outcomes through verbal and written documentation

- **Pain evaluation:** The nurse will frequently evaluate effectiveness of pain control through pain scale, patient and family satisfaction, and knowledge base

(City of Hope National Medical Center, 2011)

Conclusion

Pain is an individualized experience, which requires unique and specific management for that patient. Pain assessment is much more than “just a number”, and nurses must assess and monitor a patient’s pain experience each and every time. There are multiple considerations with the management of pain, and nurses need to act as the patient advocate to ensure that pain, and the associated suffering, is alleviated as best as possible.

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