#22 - ASSESSING PAIN (Partner Check-Off)

I acknowledge I have physically practiced and successfully learned the following skill(s):

Student: _____Date: _____

	P1	P2	P3	Comments
1. Verified the health care provider's orders.				
2. Gathered the necessary equipment and supplies.				
3. Performed hand hygiene.				
4. Introduced self to the patient and family.				
5. Provided for the patient's privacy.				
6. Identified the patient using two identifiers.				
7. Assessed the patient's risk for pain.				
8. Asked patient if he/she had any pain/discomfort.				
9. Assessed patient's response to previous pharmacological interventions. Determined if there were any side effects.				
10. Examined site of the patient's pain or discomfort when possible. Inspected the area for discoloration, swelling, or drainage. Palpated the area for any temperature change, altered sensation, pain, or areas that trigger pain. Observed the range of motion (ROM) of any involved joints. Used percussion and auscultation when necessary to identify abnormalities.				
11. Assessed the patient for physical, behavioral, and emotional signs and symptoms of pain.				
12. Used the **PQRSTU** mnemonic to assess patient's pain.				
13. Helped the patient into a comfortable position, and placed toiletries and personal items within reach.				
14. Placed the call light within easy reach, and made sure the patient knew how to use it to summon assistance.				

15. Raised the appropriate number of side rails and lowered the bed to the lowest position.				
16. Disposed of used supplies and equipment. Left the patient's room tidy.				
17. Removed and disposed of gloves, when used. Performed hand hygiene.				
18. Documented and reported the patient's response and expected or unexpected outcomes.				

S = Satisfactory **U** = Unsatisfactory **NP** = Not Performed *****=Must Perform to Pass

By signing below I acknowledge that I witnessed the skill performed and the student successfully passed the skill.

Practice 1: Evaluator:_____ Signature:_____

Practice 2: Evaluator:_____ Signature:_____

FINAL Student Evaluator:_____ Signature:_____

PAIN ASSESSMENT

PQRST

P (provokes/point)	What provokes the pain? Point to pain location.
Q (quality)	Describe pain (dull, achy, sharp, stabbing, etc? Constant/Intermittent?
R (radiation/relief)	Does it radiate (jaw, back, extremities, etc)? Does anything make it better or worse?
S (severity/s/s)	Explain the 10/10 pain scale or Face Scale and ask patient to rate pain. Symptoms associated with pain?
T (time/onset)	When did it start? Provoking factors?

COLDERRA

Characteristics	Dull, achy, sharp, stabbing, pressure?
Onset	When did it start?
Location	Where does it hurt?
Duration	How long does it last?
Exacerbation	What makes it worse?
Radiation	Does it travel?
Relief	What provides relief?
Associated s/s	Nausea, anxiety, autonomic responses?

CHARACTERISTICS: ACUTE & CHRONIC PAIN

	Acute Pain	Chronic Pain
Onset	Current	Continuous or intermittent
Duration	< 6 mo	> 6 mo
ANS response	Increased	Rarely present
Analgesia Response	Responsive	Rarely responsive

PRESTIGE MEDICAL

www.prestigemedical.com

7 86511 36258 4

3910
PAIN ASSESSMENT CARD

PRINTED IN TAIWAN

WONG-BAKER FACES PAIN RATING SCALE

Hurts Worst

Hurts Whole Lot

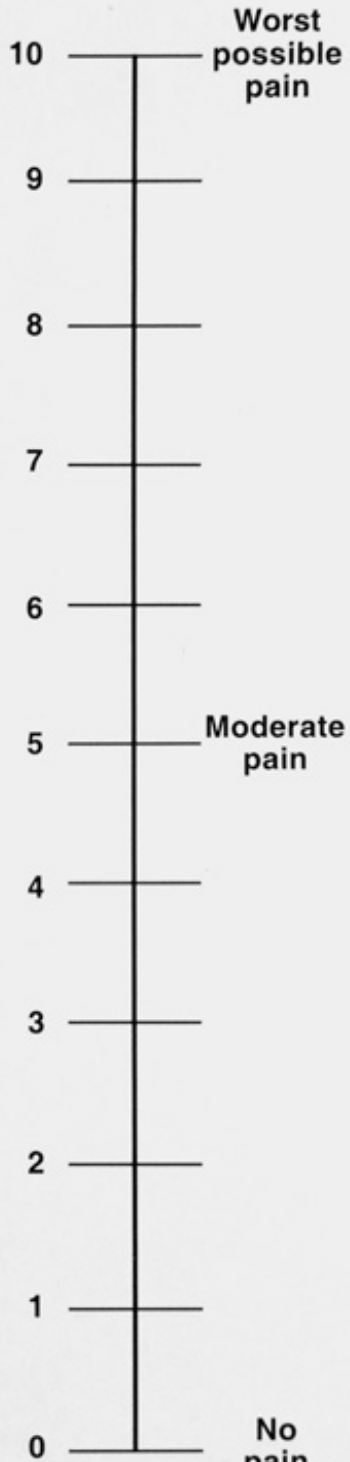
Hurts Even More

Hurts Little More

Hurts Little Bit

No Hurt

PAIN SCALE



PAIN MANAGEMENT ASSESSMENT SCALES
MERCY CARE CENTER
6/00

INSTRUCTIONS: Select the appropriate pain assessment scale and refer to this form when assessing pain. Cross-reference Scale Number on Treatment Sheet (circle scale number on treatment sheet pain assessment section). Scale selection guidelines:

Scale I = cognitively impaired residents
Scale II = non-verbal resident
Scale III = alert and oriented residents who are able to verbalize feelings without problems

Scale I.

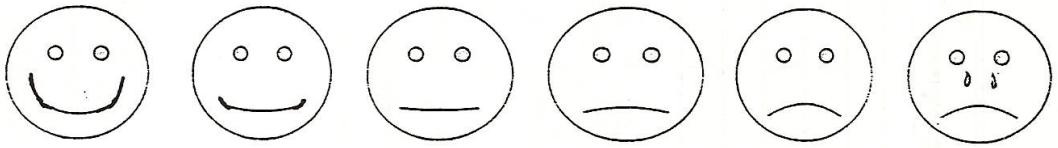
OBJECTIVE PAIN SCALE (OPS)

Parameter	0	1	2	Score
BP vs Pre-op	± 10%	± 10% - 20%	± 20% - 30%	
Crying	No	Crying but responds to TLC	Crying and does not respond to TLC	
Moving	None	Restless	Thrashing	
Agitation	Asleep or calm	Mild	Hysterical	
Verbal Evaluation	Asleep or no pain	Mild pain (cannot localize)	Moderate pain (can localize verbally or by pointing)	
			TOTAL	

Scale II.

FACES

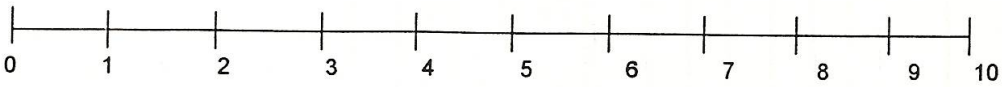
Which Face Shows How Much Hurt You Have Now?



0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Scale III.

NUMERIC PAIN INTENSITY SCALE



0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Intense Pain			Worst Pain