Pain assessment

by Marie McCullagh & Ros Wright

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A Pre-reading

What problems do you think there might be in assessing a patient's pain?

B Comprehension check

As you read the text, answer the questions below.

1. Who knows the most about the patient's pain?
2. Why is it essential for a nurse to be able to assess pain accurately?
3. How might you assess the level of pain in a younger patient?
4. What do the terms 'onset' and 'associated symptoms' refer to?

Pain assessment

The assessment of pain is a complex activity that involves a consideration of the physical and psychological aspects of the individual. Because pain is a subjective experience, the nurse needs to be able to summarise the information gained against some objective criteria. This is essential for diagnosis and for evaluating the effectiveness of interventions. Only the person experiencing the pain knows its nature, intensity, location and what it means to them. One of the most seminal, widely used and accepted definitions of pain was put forward by McCaffery (1979, p.18), who suggests that pain is 'whatever the experiencing person says it is and exists whenever he says it does'.

Assessments of the patient's pain experience

To begin with, it is essential to identify the characteristics of the client's pain. This means that the nurse should consider:

- *The type of pain*: is it crampy, stabbing, sharp? How the client describes the pain may help in diagnosing its cause. Myocardial (heart) pain is often described as stabbing, but biliary pain as cramping or aching.
- *Its intensity*: is it mild, severe or excruciating? Pain assessment scales are helpful here. The nurse can ask the patient to rate the pain on a scale of 0 to 10; zero being no pain and 10 being intolerable pain. With children, a range of pictures showing a child changing from happy to sad can be used. Colour 'mood' charts, with a series of colours from black through grey to yellow and orange, have also been used and are very useful for clients who have difficulty grasping numbers or articulating exactly what their pain is like.
- *The onset*: was it sudden or gradual? Find out when it started and in what circumstances. What makes it worse? What makes it better? What was the patient doing immediately before it happened?
- *Its duration*: is it persistent, constant or intermittent?
- *Changes in the site*: there may be tenderness, swelling, discolouration, firmness or rigidity. With appendicitis, a classic sign is the movement of pain from the umbilicus to the right iliac fossa. In a myocardial infarction (a heart attack), pain classically radiates down the arm, and with biliary pain it can radiate to the shoulder.
- *Its location*: ask the patient to be as specific as possible, for example, indicating the site by pointing.
- *Any associated symptoms*: Chart 1.2 shows some of the common symptoms of disease that can influence the response to pain.
- Signs such as redness, swelling or heat.

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Chart 1.2 Common symptoms of disease that influence the response to pain		
• Anorexia	• Cough	• Anxiety and fear
• Malaise and lassitude	• Dyspnoea	• Depression
• Constipation	• Inflammation	• Dryness of the mouth
• Diarrhoea	• Oedema	
• Nausea and vomiting	• Immobility	

Table 1.1 provides a summary of some of the issues to consider when assessing pain. In essence, this section demonstrates how much detail the nurse needs to collect when making a full assessment of the client's pain.

Table 1.1 Assessment of pain

Initial sympathetic responses to pain of low-to-moderate intensity	Parasympathetic responses to intense or chronic pain	Verbal responses	Muscular and postural responses
Increased blood pressure	Decreased blood pressure	Crying	Increased muscle tone
Increased heart rate	Decreased heart rate	Gasping	Immobilisation of the affected area
Increased respiratory rate	Weak pulse	Screaming	Rubbing movements
Decreased salivation and gastrointestinal activity	Increased gastrointestinal activity	Silence	Rocking movements
Dilated pupils	Nausea and vomiting		Drawing up of the knees
Increased perspiration	Weakness		Pacing the floor
Pallor	Decreased alertness		Thrashing and restlessness
Cool, clammy skin	Shock		Facial grimaces
Dry lips and mouth			Removal of the offending object

Adapted from *Foundations of Nursing Practice* (3rd Edition), edited by Richard Hogston and Barbara A. Marjoram: Palgrave Macmillan (2008). Reproduced with permission from Palgrave Macmillan.

C Key words

1. Match the words in the box to the definitions below.

clammy	**cramping**	**dilated**	**excruciating**	**gradual**
intermittent	**intolerable**	**pallor**	**persistent**	**radiate**

1. _____ *process occurring slowly over a period of time*
2. _____ *extremely painful*
3. _____ *happening occasionally*
4. _____ *something that continues over a long period of time*
5. _____ *unpleasantly damp or sticky*
6. _____ *feeling caused by a contraction of the muscles*
7. _____ *pale, unhealthy looking skin*
8. _____ *unbearable*
9. _____ *spreads in all directions from a particular point*
10. _____ *open wide, opposite of contracted*

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2. **Using the words in the box, write five sentences you might use to describe your patient's pain on a Nursing Assessment sheet.**

a. _____

b. _____

c. _____

d. _____

e. _____

D Vocabulary development

1. **We often use powerful images to describe pain. Think of 10 adjectives or expressions used in your language to describe pain and use a dictionary to find their equivalents in English.**

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____

2. **Share your findings with the rest of the group.**

E Discussion

1. **Write notes on the following: *What is the significance of the verbal, muscular and postural responses (Table 1.1) when responding to a patient in pain?***

2. **Now present your ideas to the rest of the group.**

F Follow-up

Choose two examples from Chart 1.2 and find out why these common symptoms might influence a patient's response to pain. Keep a record of where you have found the information.

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ANSWER KEY

A Pre-reading

It is often difficult for nurses to assess pain accurately: pain is a very subjective and personal experience; no two people will feel pain in the same way. We are able to tolerate quite intense pain if we know it is likely to only last a short time. Elderly patients may underestimate levels of pain, as they have learnt to tolerate pain over time. Children are more likely to underestimate pain as they fear the consequences, such as going to hospital.

B Comprehension check

1. The patient is the expert of their pain. Only they know the location, intensity, onset, etc. of the symptoms they are experiencing.
2. To arrive at a diagnosis and evaluate the effectiveness of their interventions.
3. Use pictures of children's faces changing from happy to sad. With older children the scale 1 to 10 could also be used.
4. *Onset* describes when the symptoms started and the context, also what improves and makes it worse. *Associated symptoms* are those occurring at the same time. These may or may not have an effect on the main condition.

C Key words

1. gradual
2. excruciating
3. intermittent
4. persistent
5. clammy
6. cramping
7. pallor
8. intolerable
9. radiate
10. dilated

D Vocabulary development

Learners may also include metaphors for pain, e.g. *it feels like I've been run over by a truck… / hit over the head with a hammer*, etc.

Encourage your learners to work together in developing their lexical competence.

E Discussion

It is important that nurses learn to acknowledge and interpret the muscular, verbal and postural responses of their patients. These may well give more information concerning the patient's symptoms. Nurses may need to acknowledge and clarify what the patient is actually feeling, and whether they could help in any way to ease the pain / make the patient feel more comfortable, etc.