

Pain assessment and management argumentative essay



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I. Introduction

As concerns have grown about the poor quality of life patients experience during the progressive illness, broadening the concept of palliative care beyond the hospice has begun to take hold in health care settings across the country (Jones, 2001). Palliative care is an approach to care for the seriously ill that has long been a part of cancer care. Both palliative care and hospice have been recognized as important bridges between the compulsion for cure-oriented care and physician-assisted suicide (Saunders & Kastenbaum, 2003). Advocates for improved care for the dying have stated that acceptance, management, and understanding of death should become fully integrated concepts in mainstream health care (Callahan, 2003).

Increasingly, palliative care is being offered to patients with noncancer chronic illness, where comprehensive symptom management and psychosocial and spiritual support can enhance the patient's and family's quality of life.

Palliative care emphasizes management of psychological, social, and spiritual problems in addition to control pain and other physical symptoms. As the definition suggests, palliative care is not care that begins when cure-focused treatment ends. The goal of palliative care is to improve the patient's and family's quality of life, and many aspects of this type of comprehensive, comfort-focused approach to care are applicable earlier in the process of life-threatening disease in conjunction with cure-focused approach treatment. However, definitions of palliative care, the services that are part of it, and the clinicians who provide it are evolving steadily.

This paper intends to discuss the difference between pain management and pain assessment in palliative care and how these are connected; thus, the essay is designed to give students the opportunity to demonstrate their understanding of a contemporary health issue involving palliative care.

II. Discussion

A. Pain Assessment

The highly subjective of pain makes pain assessment challenges for every clinician. The report of pain is a social transaction; thus, assessment of pain requires a good rapport with the person in pain. In assessing a patient with pain, the nurse reviews the patient's description of the pain and other factors that may influence pain (eg, previous experience, anxiety, and age) as well as the person's response to pain relief strategies. Documentation of the pain level as rated on a pain scale becomes part of the patient's medical record, as does a record of the pain relief obtained from interventions.

Pain assessment includes determining what level of pain relief the acutely ill patient believes is needed to recover quickly or improve function, or what level of relief the chronically or terminally ill patient requires to maintain comfort. Part of a thorough pain assessment is to understand the patient's expectations and misconceptions about pain. A person who understands that pain relief not only contributes to comfort but also hastens recovery is more likely to request or self-administer treatment appropriately (Lasch, 2000).

C. Pain Management

Pain management is considered such an important part of care that the American Pain Society coined the phrase “ Pain: The 5th Vital Sign” (Campbell, 2004) to emphasize its significance and to increase the awareness among health care professionals of the importance of effective pain management. Documentation of pain assessment is now as prominent as the documentation of the “ traditional” vital signs. Pain assessment and management are also mandated by the Joint on the Accreditation of Healthcare Organizations (JCAHO, 2006).

Calling pain the fifth vital sign suggests that the assessment of pain should be as automatic as taking a patient’s blood pressure and pulse. The JCAHO has incorporated pain and pain management into its standards. JCAHO’s standards state that “ pain is assessed in all patients” and that “ patients have the right to appropriate assessment and management of pain. These standards reflect the importance of pain management.

In health care, the primary care provider’s role is to assess and ameliorate pain by administering medications and other treatments. The nurse collaborates with the other health care professionals while administering most pain relief interventions, evaluating their effectiveness, and serving as patient advocate when the intervention is ineffective. In addition, the nurse serves as an educator to the patient and family, teaching them to manage pain relief regimen themselves when appropriate.

D. Importance of pain assessment

The factors to consider in a complete pain assessment are the intensity, timing, location, quality, personal meaning, aggravating, and alleviating
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factors, and pain behaviors. The pain assessment begins by observing the patient carefully, noting the patient's overall posture and presence or absence of overt pain behaviors and asking the person to describe, in his or her own words, the specifics of the pain. The words used to describe the pain may point toward the etiology. For example, the classic description of chest pain that results from a myocardial infarction includes pressure or squeezing on the chest. A detailed history should follow the initial description of pain.

a) Intensity

The intensity of pain ranges from none to mild discomfort to excruciating. There is no correlation between reported intensity and the stimulus that produced it. The reported intensity is influenced by the person's pain threshold and pain tolerance. Pain threshold is the smallest stimulus for which a person reports pain and the tolerance is the maximum amount of pain a person can tolerate. To understand variations, the nurse can ask about the present pain intensity as well as the least and the worst pain intensity (Rhiner, 2003). Various tools and surveys are helpful to patients trying to describe pain intensity.

b) Timing

Sometimes the etiology of pain can be determined when time aspects are known. Therefore, the nurse inquires about the onset, duration, relationship between time and intensity, and whether there are changes in rhythmic patterns. The patient is asked if the pain began suddenly or increased gradually. Sudden pain that rapidly reaches maximum intensity is indicative of tissue rupture, and immediate intervention is necessary. Pain from <https://assignbuster.com/pain-assessment-and-management-argumentative-essay/>

ischemia gradually increases and becomes intense over a longer time. The chronic pain of arthritis illustrates the usefulness of determining the relationship between time and intensity, because people with arthritis usually report that pain is worse in the morning (Rhiner, 2003).

c) Location

The location of pain is best determined by having the patient point to the area of the body involved. Some general assessment forms have drawings of human figures, and the patient is asked to shade in the area involved. This is especially helpful if the pain radiates (referred pain). The shaded figures are helpful in determining the effectiveness of treatment or change in the location of pain over time.

d) Quality

The nurse asks the patient to describe the pain in his or her own words without offering clues. For example, the patient is asked to describe what the pain feels like. Sufficient time must be allowed for the patient to describe the pain and for the nurse to carefully record all words that are used. If the patient cannot describe the quality of pain, words such as burning, aching, throbbing, or stabbing can be offered. It is important to document the exact words used to describe the pain and which words were suggested by the nurse conducting the assessment (Loeb, 2001).

e) Personal Meaning

Patients experience pain differently, and the pain experience can mean

many different things. It is important to ask how the pain has affected the
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person's daily life. Some people can continue to work or study, while others may be disabled. The patient is asked if family finances have been affected. For others, the recurrence of pain may mean worsening of the disease, such as the spread of cancer (McCaffery, 2000). The meaning attached to the pain experience helps the nurse can understand how the patient is affected and assists in planning treatment.

f) Aggravating and Alleviating Factors

The nurse asks the patient what if anything makes the pain worse and what makes it better and asks specifically about the relationship between activity and pain. This helps detect factors associated with pain. For example, in a patient with advanced metastatic cancer, pain with coughing may signal spinal cord compression. The nurse ascertains whether environmental factors influence pain since they may easily be changed to help the patient. For example, making the room warmer may help the patient and relax and may improve the patient's pain. Finally, the patient is asked if pain is influenced by or affects the quality of sleep or anxiety. Both can significantly affect pain intensity and the quality of life (Miaskowski, 2000).

Knowledge of alleviating factors assists the nurse in developing a treatment plan. Therefore, it is important to ask about the patient's use of medication (prescribed and over the counter) and the amount and frequency. In addition, the nurse asks if herbal remedies, nonpharmacologic interventions, or alternative therapies have been used with success. This information assists the nurse in determining teaching needs.

g) Pain Behaviors

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When experiencing pain, people express pain with many different behaviors. These nonverbal and behavioral expressions of pain are not consistent or reliable indicators of the quality or intensity of pain, and they should not be used to determine the presence of or the degree of pain experienced.

Patients may grimace, cry, rub the affected area, guard the affected area, or immobilize it. Others may moan, groan, grunt, or sigh. Not all patients exhibit the same behaviors, and there may be different meanings associated with the same behaviors (Melzack, 2005).

E. If the nurse fails to do a good pain assessment the management of end life care will be inadequate and its consequences to patient and family.

Before discussing what the nurse can do to intervene in the patient's pain, the nurse's role in management is reviewed. The nurse helps relieve pain by administering pain-relieving interventions (including both pharmacologic and nonpharmacologic approaches), assessing the effectiveness of those interventions, monitoring for adverse effects, and serving as an advocate for the patient when the prescribed intervention is ineffective in relieving pain (Watt-Watson, 2000). In addition, the nurse serves as an educator to the patient and family to enable them to manage the prescribed intervention themselves when appropriate. If the nurse fails to discuss and educate the patient and family regarding pain assessment and management and there is negligence on the nurse's side, the patient and his/her family will be stressed out and continually fear of what will happen. This may also lead to suicidal tendency in any of the two because they might not be able to bear the circumstances.

Moreover, one of the most difficult realities that nurses face is that, despite our very best efforts, some patients will die. Although we cannot change this fact, we can have a significant and lasting effect on the way in which patients live until they die, the manner in which the death occurs, and the enduring memories of that death for the families (Gordon, 2004). Nursing has a long history of holistic, person- and family- centered care.

Knowledge about end-of-life decisions and principles of care is essential to supporting patients during decision making and in end-of-life closure in ways that recognize their unique responses to illness and that support their values and goals. Education, clinical practice, and research concerning end-of-life care are evolving, and the need to prepare nurse and other health care professionals to care for dying has emerged as a priority (Ferrell, 2001).

III. Conclusion

The information the nurse obtains from the pain assessment is used to identify goals for managing pain. The goals identified are shared and validated with the patient. The goals identified are shared or validated with the patient. For a few patients, the goal may be elimination of the pain. For many, however, this expectation may be unrealistic. Other goals may include a decrease in the intensity, duration, or frequency of pain, and a decrease in the negative effects the pain has on the patient, and a decrease in the negative effects of pain has on the patient. For example, pain may have a negative effect by interfering with sleep and thereby hampering recovery from an acute illness or decreasing appetite. In such instances, the goals might be to sleep soundly and to take adequate nutrition. Chronic pain may

affect the person's quality of life by interfering with work or interpersonal relationships. Thus, a goal may be to decrease time lost from work or to increase the quality of interpersonal relationships.