CALIFORNIA NURSES ASSOCIATION

NATIONAL NURSES ORGANIZING COMMITTEE

Nursing Practice & Patient Advocacy Alert

Pain Assessment By The Registered Nurse

Issues relating to the assessment of pain have arisen with relation to whom and when pain assessments should be performed. Because of confusion created by nursing management in that they have assigned UAPs the responsibility for assessing the patient's pain, the California Nurses Association has clarified the issue with the Board of Registered Nursing. Based on the clarification, the following practice alert identifies who (the RN) and when (at the time vital signs are taken) such pain assessments should occur.

Assembly Bill 791 (Thomson) was signed into law by Governor Gray Davis on September 15, 1999, and is effective January 1, 2000. Section 1254.7 was added to the Health and Safety Code (H&SC) as part of this bill. H&SC §1254.7 provides in pertinent part:

> (a) It is the intent of the Legislature that pain be assessed and treated promptly, effectively, and for as long as pain persists.
> (b) Every health facility licensed pursuant to this chapter shall, as a condition of licensure, include pain as an item to be assessed at the same time as vital signs are taken. The health facility shall insure that pain assessment is performed in a consistent manner that is appropriate to the patient. The pain assessment shall be noted in the patient's chart in a manner consistent with other vital signs.

The RN is legally responsible for analyzing, synthesizing and evaluating data collected on patients, and determining whether additional assessment or intervention is warranted.

This is stated in the Nursing Practice Act, Business and Professions Code Sec 2725(d):

Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (1) determination of whether such signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics; and (2) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

The direct care RN shall conduct ongoing pain assessment through direct observation and direct communication on all their patients including the patients assigned to any subordinates under the clinical supervision of the direct care RN. Pain assessment shall be performed by the direct care RN at the same time vital signs are taken based on the physicians order. (i.e., if the MD orders vital signs q4hours, the RN must assess the patient's pain at least q4hours at the time he/she takes the patients vital signs.)