

## **Pain Assessment (and Reassessment): Critical Facts**

### **1. The assessment imperative:**

- Regulatory standards, hospital policy, multidisciplinary and multispecialty professional care standards, and human compassion demand that pain be appropriately managed
- Assessment is the key to the design and implementation of appropriate interventions
- A consistent process of monitoring and reassessment ensure the safety and efficacy of the intervention.
- Special effort must be made to ensure that pain is adequately assessed in children, elders, ethnic minorities, and those unable to speak for themselves.

### **2. Pain is 100% subjective:**

- There is no instrumentation or test that can measure pain
- Self-report is the gold standard for pain assessment for cognitively intact adults and most children 3 years and older.
- An observer cannot tell definitively by behavior or appearance whether a person is in pain or how much pain the person has
- Physiologic measures (such as blood pressure and pulse) are non-specific and imprecise variables that may be indicative of acute stress or distress. They cannot be used to identify or monitor chronic pain
- Clinicians and family members consistently underestimate, by a wide margin, the pain reported by patients
- When the patient is unable to reliably self-report (e.g., young children and elders with advanced dementia), indirect indicators such as physiologic signs and behavioral cues may be used to estimate the presence and severity of pain

### **3. What is assessed in a pain assessment?**

- Pain has cognitive, affective, behavioral, and sensory elements
- The initial assessment includes history (including current and previous treatment), description, and impact of the pain
- A mnemonic that may help the clinician to systematically gather information on the multiple dimensions of pain is PAINED (see expanded explanation in NPM 2.14, Guidelines for Pain Assessment and Management):
  - **P** = place and time that pain occurs
  - **A** = Amount/severity of pain
  - **I** = Intensifiers: what makes it worse
  - **N** = Nullifiers: what makes it better (including medications)
  - **E** = Effect on ADL's, mood, relationships, etc.
  - **D** = Descriptors: use patient's own words
- Comfort-function goals are established collaboratively with the patient; unrealistic expectations need to be explored and corrected

### **4. Pain severity instruments:**

- One of the more straightforward elements of the pain assessment is determining pain severity.
  - This knowledge is used in the treatment planning process and can be used as a simple measure of the effectiveness of the intervention.

- A convenient and clinically relevant way to quantify and compare pain over time is through the use of numerical pain scores.
  - 0 – 10 (for most cognitively intact adults and children around 7 and up)
  - Wong-Baker FACES (children 3 and up and adults who prefer a non-numerical scale)—the clinician “translates” patient responses to a number for the purposes of documentation
  - Verbal descriptor—for patients uncomfortable with a numerical scale
- Basic principles of assessing pain in children are the same as in adults, but the developmental level of the child must be considered when determining the appropriate assessment instruments

#### 5. **Assessing pain in the difficult to assess patient:**

- Pain assessment is a systematic process:
  - must be done consistently in order to have any meaning
  - develop consensus on parameters/criteria and instruments (if available) for particular subsets of patients
- Behavioral scales and physiologic measures
  - FLACC (pre-verbal children and occasionally non-verbal adults)
  - N-PASS (neonates)
  - PAINAD (elders with advanced dementia); people with early dementia may, with patience on the part of clinicians, be able to self-report, including the 0 – 10 or FACES scale
- Solicit input of family in interpreting behavior, especially in children and non-sedated adults—but remember that family members are not much better than professionals in quantifying a patient’s pain
- Adopt a practice of assuming pain to be present (APP = assume pain present) and/or actively attempt to rule out pain as a cause of behavioral changes or changes in physiologic/vital signs
  - “would this condition or procedure cause pain in an alert, cognitively intact person?”
  - Sedation does not provide sufficient protection against experiencing pain
  - Neuromuscular blockade prevents a patient from reacting to pain, but prevent pain or provide any pain relief

#### 6. **Monitoring and reassessment:**

- When to reassess
  - On a scheduled basis for patients who report pain on a previous assessment; the assessment interval is incorporated into the treatment plan and may be based on
    - Unit standard or guideline for routine reassessment
    - Patient condition, including cause of pain, pain severity, and co-morbidities
  - When new pain or an exacerbation of pain is reported
  - At a reasonable interval after any intervention for the pain
    - No more than 30 minutes after IV analgesic
    - No more than 60 minutes after PO analgesic
  - At a reasonable interval after an activity or procedure that causes/exacerbates pain
  - Before and after unit transfer
  - At the time of change in caregivers
- What to monitor
  - Pain score

- Sedation score
- Functionality
- Achievement of comfort-function goals

<b>Sedation Scale</b>
S = Normal sleep, easily arousable
1 = Awake, alert
2 = Slightly drowsy, easily aroused
3 = Frequently drowsy, arousable, drifts off to sleep during conversation
4 = somnolent, minimal or no response to physical stimulation

**7. Documentation:**

- Documentation is the means by which inter-and intradisciplinary collaborative practice is maintained in assessing and treating the pain.
  - Even when initial assessments are appropriately documented , the reassessment and monitoring functions tend to be very poorly documented, potentially interfering with optimal pain management
- Initial pain assessment is documented on the admission assessment form.
- Initial comfort-function goals are documented on the admission assessment form; changes in goals are recorded in the progress note
- Documentation of serial vital signs, pain severity, sedation, and “assume pain present” should be done on the designated flow sheet. This permits a readily accessible view of progress in treating pain.
- Documentation of non-pharmacologic interventions and the patient response is in the Progress Note
- Administration of scheduled medications is documented on the appropriate medication sheets; response to this treatment is covered in the routine reassessment interval
- PRN analgesics require documentation in the progress note as well as the medication sheet:
  - Patient complaint, including pain severity score
  - Rationale for choosing the medication or dose if more than one is available
  - Patient response, with reference to the improvement (or lack thereof) in the condition/complaint that precipitated giving the PRN medication; this will include at least the post-intervention pain score.