

M_{ass} G_{eneral} H_{ospital} Pain Assessment & Reassessment (M-PAR): White 9

Pain Assessment: All patients are screened for the presence of pain on admission, transfer and after procedures. When pain is present, more details need to be evaluated in addition to intensity, such as: sensation descriptors, location, pattern (constant, intermittent), factors that intensify or alleviate pain and effects on activity or bio-psycho-social functioning. Acronyms like PAINED or WILDA can be used to guide this expanded assessment.

P	Place (location) and time	W	Words describing pain
A	Amount (severity on 0-10 scale)	I	Intensity (severity on 0-10 scale)
I	Intensifiers (what makes it worse?)	L	Location (body part affected)
N	Nullifiers (what makes it better?)	D	Duration (change since starting)
E	Effects on ADLs, sleep, concentration	A	Aggravating/Alleviating factors
D	Descriptors (What does it feel like)?		

Pain Reassessment: Timely, skilled reassessment of pain is needed to determine the safety and efficacy of intervention, as well as individualize treatment plans based response. Reassessments of the intensity, quality and responses to treatments are required following the administration of any analgesic. Reassessments are timed to coincide with anticipated effects of the analgesic (e.g. within 4 hr after prn dose) and every 4 hours for patients with scheduled analgesics, continuous, PCA or epidural infusions. Three essential components of reassessments are summarized as the **3-A's; Activity, Adverse effects, and Analgesia**.

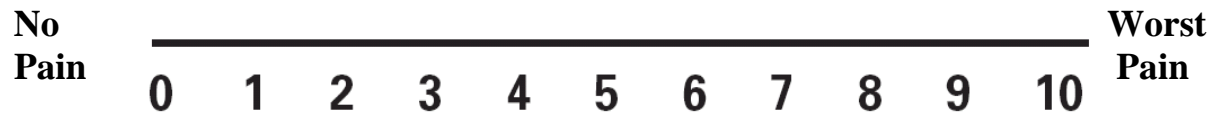
- 1) Activity:** Note level of improvement due to reduced interference from pain, and any safety issues related to risk of injury due to the effects of the medicine.
- 2) Adverse effects:** Note any signs of side effects, toxicity, technology-related complications or aberrant behaviors. Specifically, note any sedation, respiratory depression or abdominal pain.
- 3) Analgesia:** this can be done in 1 of 3 ways
 - a) Rate the pain intensity on the same scale before and after the intervention –or-
 - b) Ask the patient to estimate a percent reduction in the pain intensity – or-
 - c) Ask for a description of the amount of relief, (some relief, good relief, complete relief)

For charting purposes describe patient responses in the progress notes or calculate a follow-up score by reducing the pre-intervention score by the corresponding percentage of relief.

0%	10%	25%	50%	75%	100%
No Relief	Minimal Effect	Some Effect	Good Effect	Excellent Effect	Complete Relief

M_{ass} G_{eneral} H_{ospital} Pain Assessment & Reassessment (M-PAR) Scale White 9

Numeric Pain Scale (NPS)



Verbal Descriptor Pain Scale

(0)	(2)	(4)	(6)	(8)	(10)
No Pain	Mild	Moderate	Severe	Extreme	Worst Pain

Adjective Rating Scale (ARS)

(0)	(2)	(4)	(6)	(8)	(10)
No Pain	Mild	Discomforting	Distressing	Horrible	Excruciating Pain

Functional Pain Scale (FPS)

(0)	(2)	(4)	(6)	(8)	(10)
No Pain	Tolerable activities not prevented	Tolerable prevents some active activities	Intolerable prevents all active, (not passive) activities	Intolerable prevents all passive activities	Intolerable incapacitated, unable to do anything or speak due to pain

Active activities : usual activities or those requiring effort (turning, walking, etc)

Passive activities: talking on phone, watching TV, reading

Checklist for non-Verbal Pain Indicators

Vocal Expressions: Expresses pain, or moans, groans, grunts, cries, sighs, gasps

Facial Expression: Wince, grimace, furrowed brow, tight lips, jaw drop, clenched jaw, distorted expression

Bracing: Clutching or holding onto side rails, bed tray, table, or affected area of pain

Restlessness: Shifting position, hand movements, unable to keep still

Rubbing: touching or massaging affected area

0 = Behavior not observed

1 = Behavior observed *AT REST*

1 = Behavior observed *WITH MOVEMENT*

(score 2 if both rest and movement)

Vocal Expressions: ____ **Restlessness:** ____

Facial Expression: ____ **Rubbing:** ____

Bracing: ____

Total Score: ____