

Pain Topics

Pain Assessment in the Difficult-to-Assess Patient

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Pain assessment: a process, not a tool

A systematic approach to pain assessment is critical to optimal pain management. Using common language and methods is the most effective way to facilitate collaboration, consistency and continuity, and to decrease the risk of confusion and error. Because the patient report is the most reliable indicator of pain, the vast majority of pediatric and adult patients can have the severity of their pain adequately assessed using standard instruments such as the 0-10 scale or the Wong-Baker FACES scale. However, the potential for pain should not be overlooked in patients who cannot reliably report their pain, and provision must be made for patients who are unable to use the standard tools.

Some cognitively intact adults have difficulty conceptualizing pain on a 0-10 horizontal scale. Turning the scale on its side (like a thermometer) is helpful to some of them. Some patients (especially, but not exclusively, elders) associate the term “pain” only with severe discomfort, so may deny pain even when they appear to be uncomfortable. It may be useful to try other terms such as “ache,” “sore,” or “discomfort.” Asking both children and adults what words they use when they hurt will help patients and caregivers adopt common terminology. This in turn can facilitate the use of a verbal descriptor scale that the nurse or physician can consistently use in place of the standard 0-10 scale. Please note that a “custom” verbal descriptor scale developed for one patient is not valid for another.

In pediatrics, selection of appropriate assessment tools should consider developmental levels rather than simply an age-appropriate tool. For example, systematic assessment of behaviors is the primary means of pain assessment in preverbal children, but one tool may be more appropriate to neonates (e.g., N-PASS) and another to small or developmentally delayed children (e.g., FLACC). Parental involvement is also usually a critical component in the pain assessment of children. It is particularly difficult to assess pain in children with severe cognitive impairments. Attempts have been made to validate instruments to assess pain in this population (1), but there is not yet consensus on a standard procedure for assessing pain in these children. Clinicians, parents, and child life specialists should collaboratively attempt individualized systematic assessment and intervention, taking into consideration the points outlined in the final section of this paper.

The adult patients who are most difficult to assess are those who are most seriously ill or injured, and those with dementia. Both groups are at high risk for unrecognized and under-treated pain. When possible, patient self-report, even in the critical care setting, remains the “gold standard.” However, we are frequently reduced to clinical judgment, behavioral signs, and, sometimes, physiologic signs in assessing these patients. An instrument (PAINAD) has recently been validated for use in assessing pain in elders with dementia by systematically observing behaviors and scoring them in a standard manner.(2) Research is underway to develop pain assessment instruments and processes for use in the critical care setting for cases in which the common tools are not applicable.(3,4) Patients who are comatose, are physically or chemically immobilized, sedated, or disoriented are at risk for pain and are particularly difficult to assess. When a standardized instrument is available and applicable to a patient’s condition, it should be used. As with children, clinicians and family (as appropriate) should collaboratively attempt individualized systematic assessment and intervention, taking into consideration the points outlined in the final section.

Appropriate and inappropriate use of assessment instruments

Pain assessment is a systematic process that usually includes the use of a standardized instrument. When a pain assessment instrument thought to be appropriate to the patient’s situation is selected, it should be used consistently—and the name of the instrument documented. Unless there is a change in condition that warrants use of a different instrument (a change that should be clearly documented), stick with the original instrument. The score on one instrument cannot be equated to that on another, because different factors are used to reach the score. Furthermore, a score on a behavioral scale is not equivalent to a pain severity score; only self-report can

provide a severity score.(10) Don't attempt to apply an instrument that has not been validated in your population. Similarly, don't attempt to use an instrument in a population for which no instrument has been developed. For example, there are no instruments for patients who are chemically paralyzed or who have severe neurological injury.

The most difficult to assess

The patients mentioned in the previous sentence are among the most difficult to assess. Patients who are chemically paralyzed are unable to move, grimace, or fight a ventilator. Those with brain injury may have behaviors caused by the injury that may mimic those expected in a patient with pain. In these and other difficult cases we need to make judgments based on patient history and current environment. Does the patient have a pre-existing painful condition? Is acute pain from burns, trauma, or surgery a reasonable expectation? Are care measures, such as turning (found to be the single greatest source of pain in a landmark ICU study) (11) and invasive procedures, potentially painful? Can the family provide information on behaviors that they have associated with pain in the past?

For situations in which there is no available instrument to assist with assessment, it is legitimate to document "Unable to quantify." If there are conditions in the patient history or care environment that suggest that pain is likely, "Assume Pain Present (APP)" may be documented.(10) Note that APP is a conclusion reached as a result of assessment. The criteria or factors used to reach that conclusion must be documented. Collaborative decision-making should be used to determine reasonable interventions, and post-intervention reassessment documented.

Reassessment

The same process and factors used in an initial pain assessment can be used to assess progress in relieving pain. For example, depending on the setting and circumstances, an analgesic trial may be initiated to help determine if the observed behaviors are indeed related to pain.(10,13) Other pharmacologic and non-pharmacologic measures may also be tried. Changes (or lack thereof) in the index behaviors (those used in the initial assessment) can be used to judge the effectiveness of various interventions.

CRITICAL ELEMENTS TO CONSIDER

A recently published review (12) and new [recommendations](#) from the American Society for Pain Management Nursing ([ASPMN](#)) support this process for assessing pain in non-verbal patients.(13) The ASPMN recommendations stress that a self report should be elicited whenever possible, even if the patient is able to respond only by blinking or other purposeful movement. The following points should be considered in assessing pain in patients who are not able to provide their own report:

- A condition or procedure that is likely to cause pain in a cognitively intact patient is likely to cause a similar amount of pain in a cognitively impaired, comatose, sedated, immobilized, or demented person.
- Physiologic measures are nonspecific indicators of stress or distress. They are useful surrogate indicators for acute pain (but not for persistent pain) when they are used in conjunction with other observations.
- Behavioral signs are useful surrogate indicators for acute pain and sometimes for persistent pain. However, they should be monitored and documented systematically. Whenever possible, a tool validated in the patient's population should be used.
- Family members (particularly in the case of children) may be able to provide valuable insight into behaviors that may be associated with pain.
- Neuromuscular blockade may prevent behaviors that are indicative of pain, but does so without providing analgesia.
- Sedation may prevent behaviors that are indicative of pain, but usually does so without providing analgesia.
- An analgesic trial can be both diagnostic and therapeutic.
- Creativity and sensitivity to individual patient needs facilitates pain assessment and management.
- Consistent, collaborative, systematic assessment is the key to adequate pain management in all populations.

Rapid Recap

Some patients are unable to provide a self-report or may be impaired by disease or treatments. These patients are at high risk for unrecognized pain. A combination of the following approaches may be helpful:

- Consider the commonly used pain assessment instruments to see if an instrument appropriate to the patient's developmental stage and/or condition is available
- Consult with an expert colleague, such as the Clinical Nurse Specialist, to help identify pain indicators
- Use physiologic signs as surrogate markers of acute pain
- Use behavioral signs as surrogate markers of acute or chronic pain
- Use family members to assist in identifying pain behaviors
- If a condition or procedure is painful for a responsive patient, assume that it is painful for an unresponsive patient, unless there is reason to believe otherwise
- If the patient reported pain prior to becoming unresponsive, assume that the painful condition persists, unless there is reason to believe otherwise
- Document the pain indicators you use so that colleagues may share a consistent method of assessment

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