

MGH Pain Guidelines Q & A

1. You say that pain should be assessed and reassessed “regularly” (Page 1). What does that mean?

Answer: Pain assessment should be done systematically and consistently on a schedule and in a manner that makes clinical sense for an individual patient. It will therefore vary with setting, patient condition, and care environment. In the case of a patient undergoing a colonoscopy, or a patient in the first couple of hours postop in the PACU, pain should be assessed every few minutes. This can usually be done in conjunction with checking IV lines, vital signs, level of alertness, and so forth. A patient with chronic stable pain can be assessed daily, every shift, prior to analgesic administration, or on a schedule mutually determined by the patient and care team. There is plenty of room for judgment in deciding on the best schedule for an individual who falls somewhere between the relatively intense and relatively relaxed scenarios presented. Most units have standard schedules that fit the needs of most patients and clinicians. Severe acute pain requires more frequent reassessment and monitoring to evaluate both effectiveness of interventions and possible side effects.

2. Some of my patients get irritated when I keep asking for a pain score. What should I do?

Answer: The pain score provides a clinically effective way to monitor progress over time, during various environmental conditions, and across caregivers and settings. It is crucial to care across the continuum and provides patient and caregiver a consistent means of communicating about pain severity. It is an important part of including the patient as collaborator in the treatment process. Explaining this background to the patient may help. Perhaps more importantly, use the pain score in the context of the overall assessment of pain and of the patient condition. Individualizing assessments and care are a key to both effective pain management and patient satisfaction. Patients who feel involved in their care, rather than sensing that asking about pain severity is just a ritual, are more likely to participate and cooperate.

3. Does using “Assume Pain Present (APP)” mean I can skip the assessment?

Answer: APP is a conclusion based on an assessment of a nonverbal patient, usually when there is no appropriate behavioral assessment instrument to quantify behaviors systematically. APP is the result of observing behaviors (if present); patient history of a painful condition; illness, trauma, or surgery that would be expected to cause pain; presence of instrumentation such as chest tubes or ventilators; extended stay in a critical care setting; invasive and non-invasive procedures that are likely to be painful. APP requires pain-relieving interventions and evaluation of effectiveness. The catch is that you used APP in the first place because there are few or even no specific indicators (consider the patient who is chemically paralyzed, for example) on which to base your evaluation. Your “evaluation” may be limited to reviewing your process and recording any behavioral or physiologic changes that are detectable. As long as there are conditions that could cause pain, APP should be used. As long as APP is used, attempts to minimize pain are ethically required.

4. Can I do an assessment if I can't find an assessment tool for my patient?

Answer: Pain assessment is a systematic process. Assessment tools or instruments are only one part of an assessment (see the PAINED process in the Guidelines). They are useful because they help to quantify the pain experience, which helps clinicians to evaluate the effectiveness of interventions. See Questions 5 & 6, below.

5. Can I use an assessment tool that is not mentioned in the Guidelines?

Answer: Only a few of the many instruments available are mentioned in the Guidelines. The vast majority of adult and pediatric patients can self-report that they have pain and how severe it is using either the 0 – 10 or Wong-Baker FACES scale. For simplicity and consistency, MGH has chosen these two as the “default” instruments. A small subset of patients are able to self-report, but are unable to use one of these instruments. If they have used another instrument in the past with which they are comfortable, by all means use that tool. For patients who can't self-report, there are many instruments available. We have chosen the PAINAD, the FLACC, and N-PASS for elders with dementia, small children, and neonates, respectively. Again, simplicity and consistency were the goals. Other published instruments have primarily been validated in critical care settings. Use of any of these instruments is encouraged (as long as one tool is used consistently for a particular patient).

Selecting an instrument must follow a collaborative approach that may involve multidisciplinary colleagues, the unit CNS, Pain Relief Champions and/or Resource Nurse, and the Pain CNS. Make sure that everyone caring for the patient understands the objectives, terminology, clinical application, and scoring for the tool. Patient care units that frequently need to use a behavioral tool should investigate those that are available and select a default instrument that usually works for their primary patient population and clinical staff. Remember that the score obtained using one behavioral instrument cannot be equated to that from another instrument. Also, *the score on a behavioral instrument is not a pain severity score; it is a pain behaviors score.*

6. What if I don't know if there is a tool available that would work for my patient?

Answer: This will require a little research and use of expert resources. The first step is to assess the situation. For example, if the patient is chemically paralyzed, your search is over: the patient cannot have behaviors and thus there is no behavioral instrument that can have an adjunctive role in pain assessment [see Appendix K of the Guidelines for appropriate use of “Unable to Quantify” and “Assume Pain Present (APP)"]. The needs and condition of a specific patient or the “typical” patient in your population (e.g., burn unit; SICU) must be evaluated. An instrument developed and validated for a different population cannot be used. For example, the PAINAD, developed for use with elders with severe dementia in a medical setting cannot be used in the SICU. Selecting an instrument must follow a collaborative approach that may involve multidisciplinary colleagues; the unit CNS, Pain Relief Champions, and/or Resource Nurse; and the Pain CNS.

7. My patient says she doesn't have pain, but she's grimacing & guarding. How can I "believe" the patient self-report when I see evidence that contradicts it?

Answer: Pain, like other symptoms, is 100% subjective. It cannot be measured (pain severity tools are only used to quantify the patient's report of pain) or detected. The patient report of pain presence or severity is only one element of a complete assessment (see the PAINED mnemonic in the Guidelines). When there is a "disconnect" among the elements, further assessment is called for. In this case, it could be a matter of language or culture. We need to try to get on "the same page" with our patient so that we both have the same understanding of the phenomenon we call "pain." Perhaps the patient's denial of pain relates to fear of opioids or injections. She may be concerned that the pain means her condition is worsening. Assuming it is culturally appropriate, be forthright with the patient. Explain your concern about inconsistencies and the potential that she could have unnecessary suffering. Explain the importance of pain management to overall recovery and healthy functioning. Express your concerns to colleagues and family as well—they may have valuable insights that will help. These disconnects are frustrating and sometimes difficult, but are not uncommon. They highlight the need for patient advocacy and the highest level of professional care.