CONSIDERATIONS:

1. Pain is the 5th vital sign:
   a. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage (International Association for the Study of Pain).
   b. Pain is whatever the patient states it is, existing whenever the patient states it does (Pasero & McCaffery, 2011).
   c. Unrelieved pain can have negative physical, psychological, spiritual, social and financial consequences
   d. Pain should be assessed and reassessed at every visit and as needed to assure patient comfort
2. Pain is a multidimensional experience, influenced by cultural backgrounds and life experiences, affecting values and beliefs about the meaning of pain and how it should be managed.
3. The ability of an agency's clinicians to assess and address patients' pain is an important indicator of the agency's use of best practices and evidence-based care:
   a. OASIS questions M1240 and M1242 acknowledge that best practices include:
      i. A standardized screening tool is the first step to effective pain management
      ii. Relieving pain that interferes with independence and meaningful activities is an indicator of quality care
   b. QAPI measures how well a patient's pain was addressed within the first 48 hours of a patient's admission to hospice
4. Pain assessment consists of two steps:
   a. Screen for presence of pain
   b. If screen is positive, perform a comprehensive pain assessment
5. Standardized validated tools that **screen for pain** include:
   a. For Adults:
      i. Numeric Rating Scale: Rates pain 0 - 10 scale; verbal or written
      ii. Visual Analog Scale: Patient points/marks a place on a line from 0 to 100 to indicate pain intensity
      iii. Verbal Categorical Scale: Patient identifies pain as mild, moderate or severe
   b. For children:
      i. Wong-Baker FACES scale: Aligns the numeric rating scale with the appropriate sad/neutral/happy face
      ii. FLAAC Scale: Evaluates indictors of a baby's pain: face, legs, activity, cry, and consolability
   c. Cognitively Impaired:
      i. Pain Assessment in Advanced Dementia (PAINAD)
      ii. Checklist of Non-verbal Pain Indicators (CNPI)
      iii. Pain Assessment Checklist for Seniors with Severe Dementia (PACSLAC)
      iv. Assessment for Discomfort in Dementia
   d. A tool that combines several of these validated tools into a one page tool is the DoD/VA Pain Rating Scale. (See Addendum; works best in color)
6. If the patient screens positive for pain, the clinician needs to determine:
   a. How urgently pain needs to be resolved
   b. What are the dimensions of the patient's pain that need to be known to address the pain appropriately = Comprehensive Pain Assessment
7. Severe or acute pain necessitates immediate medical intervention.
   a. Ascertain the patient's comfort/function goals.
   b. Determine a time frame to treat and achieve the expected outcome.
      1. Use the patient's stated target number on the pain intensity scale to know when the expected outcome is reached.
      2. For nonverbal patients, use a target number on the age/ability-appropriate scale to determine if expected outcome achieved.
8. Validated and helpful tools for performing a **Comprehensive Pain Assessment** include:
   a. The McGill Pain Questionnaire (Melzak, 1987)
   b. Memorial Pain Assessment Card (Fishman, 1987)
   c. Brief Pain Inventory (Cleeland, 1994)
   d. Measurement Tool for Neuropathic Pain: Neuropathy Pain Scale (Pasero, 2011)
   e. Alberta Breakthrough Pain Assessment Tool (Pasero, 2011)
9. Pain Assessment Pointers:
   a. Use the same intensity rating scale for each patient reassessment
   b. Pain screening/intensity scales are only valid for the population in which the tool was tested. For example, the Wong-Baker FACES Scale is valid for pediatric patients; it is not a standardized validated tool for patients who do not speak English
   c. To perform an effective comprehensive pain assessment for a patient who does not speak English, an interpreter is required

EQUIPMENT:

Agency Pain Scale
Comprehensive Pain Assessment Tool

PROCEDURE:

1. Pain Screening:
   a. On admission, explain that excessive pain can slow recovery and/or inhibit well-being, so you would like to ask about the patient's pain
   b. Inquire and observe if pain is affecting the patient's ability to perform ADLs, including sleeping, and activities that are meaningful to the patient
   c. Administer one of the standardized validated screening/intensity tools
   d. If Patient Reports Pain:
      i. Ask: What is your goal for pain relief
      ii. Determine the urgency of the patient's pain and if a comprehensive pain assessment and management is needed immediately
2. Comprehensive Pain Assessment:
   a. Ask about the physical characteristics of the pain:
      i. Location: Where is the pain located? Is there more than one location? Are they the same or different kinds of pain? Can you point to where the pain is the worst?
      ii. Intensity: Use the same scale used in screening: How intense is the pain: Now? At its best? At its worst? What level would be acceptable to you?
      iii. Quality: Can you describe what the pain feels like? Is it aching? Squeezing? Shock-like?
      iv. Timing: Does the pain come and go? Or is it continuous? Does it come on suddenly or gradually? Is it getting better or worse? What caused it to start?
      v. Aggravating factors: What makes the pain get worse?
      vi. Alleviating factors: What decreases the pain?
      vii. Associated symptoms: Do you think the pain is related to other problems you are having? What other problems are you having?
   b. Ask about the patient's pain management plan:
      i. Pain medication: Did the doctor give you medication for the pain? How well does it work? How long does it help? When did you last take it? When do you think you will take it again? How many pills do you take each time?
      ii. Pain medication side effects: Does the medication cause you any problems? Nausea? Constipation? Itching?
      iii. Other Treatments: Are you doing anything else to help with the pain? How well does it work? Have you ever used anything in the past that might be helpful now?
      iv. History of Abuse: Did you ever take pain pills before? Did you have any trouble with them? Getting off of them?
   c. Ask about effect of pain on functional status. Use the pain intensity scale again:
      i. ADLs: How much does the pain interfere with your activities? Grooming? Dressing? Bathing? Toileting? Getting about?
      ii. Sleeping: Does it keep you up at night? Does it wake you up?
      iii. Eating: Does it affect your appetite? Are you able to eat?
   d. Ask about effect of pain on quality of life:
      i. How has the pain affected your relationship with others? With your enjoyment of life? With your spiritual perspective?
      ii. What would you be doing right now if your pain were improved?
      iii. What is the most difficult aspect for you with regard to your pain?
3. Cognitively Impaired Patient:
   a. Always ask if the patient has pain. If the patient cannot self-report, document in the medical record and identify the means to assess pain.
   b. Tell the caregiver that the patient seems to be uncomfortable or in pain. Ask about the caregiver's insights and concerns about the patient's behavior
   c. Ask the caregiver as many of the Comprehensive Pain Assessment questions as seem appropriate
   d. Ask about specific problems the patient may be having: When was the patient's last bowel movement? Could something be hurting the patient? Recent fall? Pins in clothing? Sores?
   e. Perform a physical assessment, looking for sources of pain, infection/inflammation, trauma, etc.
   f. Assess through an analgesic trial. With doctor's orders, see if analgesics improve the patient's behaviors that indicate pain

AFTER CARE:

1. If patient has moderate to severe pain, take action to relieve the pain. Do not document the patient has pain and do nothing about it.
2. Document in patient's record:
   a. Standardized pain tool used and patient's measurement
   b. Comprehensive pain assessment
   c. Plan for pain management and reassessment of pain

   d. Any recommended follow-up actions based on findings from pain assessment
   e. Any teaching provided to patient/caregiver about pain and its management
   f. Any communication with the physician and team members
3. See procedures for Pain Management, including complimentary therapies.
4. Communicate with physician about pain management plan and its effectiveness/ineffectiveness.
5. Consider referral to:
   a. Pain management specialist
   b. Physical Therapy movement based strategies for relieving pain
   c. Occupational Therapy for splinting/devices to relieve pain

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