Pain Assessment and Management

Policy #400.020 Administrative Manual
Objectives

• Identify appropriate pain rating scale used to screen patients for presence of pain based on patient population
• Describe time-frame to perform initial screening for pain and frequency thereafter
• Describe time-frame to reassess for pain after pharmacologic and non-pharmacologic pain relieving interventions
Policy Statement

- It is the policy of JHS to provide a consistent, interdisciplinary approach to acute/chronic pain management
- Policy applies to all patients
- Pain is evaluated through the continuum of care
- Gender, age, personal, cultural, spiritual and ethnic beliefs are considered in individualized approach to pain management
Definitions: Pain

- **Pain:**
  - An unpleasant sensory and emotional experience associated with actual or potential tissue damage

- **Acute pain:**
  - Origin of pain usually known
  - Usually acute onset with limited duration
  - May be mild to extremely disabling/dysfunctional
  - Vital signs may not be reliable indicator, but may be affected by other factors
  - Can be easily treated or controlled with immediate interventions
  - Pain usually resolves when cause is treated
Definitions: Pain (cont.)

• **Chronic pain:**
  – Origin of pain may be unknown
  – Defined as “disease of pain”. Origin, duration, intensity, symptoms vary
  – Initially may start as acute pain and develop into chronic pain
  – Changes in vital signs to pain are diminished
  – Requires prompt/continuous monitoring with multiple interventions
  – Ongoing physical and psychological limits, resulting in fatigue, exhaustion, depression, and social isolation
  – May required higher doses of pain medication
Pain Assessment and Educating Patient

Healthcare provider will:
• Screen patients for presence of pain on admission and every shift with vital signs, using appropriate pain rating scale
• Educate patients to report pain/unrelieved pain, signs/symptoms of adverse effects of pain medication
• Establish goal for pain relief with patient/significant other and develop plan to achieve goal
• Document patient’s goal on admission and every 24 hours
• If patient is able to verbalize, use numeric pain rating scale to assess self-reported severity of pain
Numeric Pain Intensity Scale

For patients who are capable of verbal communication of the intensity of their own pain
Pain Assessment

• If pain is present, use PQRST approach to characterize pain on admission and every 24 hours:
  P – Provocative factors (what makes pain worse or causes pain to occur? or Palliative factors (what makes pain better?)
  Q – Quality (e.g., gnawing, stabbing, pressure, aching, shooting, burning, numbing, throbbing, sharp, nagging, tender)
  R – Region/radiation (localized vs. radiating)
  S – Severity (using specific rating scale)
  T – Temporal aspects (onset, duration, frequency of pattern – intermittent or constant)
Wong-Baker FACES® Pain Rating Scale

- For non-verbal patients who can communicate their pain level by pointing to a face that most resembles their pain intensity. Both children and adults may use Wong-Baker FACES® Pain Rating Scale.

Use with Pediatric Patients
Wong-Baker FACES® Pain Rating Scale

Use with Adult Patients

Numeric Rating Scale

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Possible Pain

Wong-Baker FACES® Pain Rating Scale

0 2 4 6 8 10
No Pain A Little Pain A Little More Pain Even More Pain A Whole Lot Of Pain Worst Pain

Wording modified for adult use. Used with permission.
Patients Unable to Communicate

- Assess pain using appropriate pain scale:
  - Critical Care Pain Observation Tool (CPOT)
  - FLACC Scale
- Presence of pain-related behaviors (facial expression, movement, posturing), vocalization, physiological indicators (HR, BP, RR) is cue to perform pain assessment using appropriate pain rating scale
- With conditions/procedures assumed to be painful, presence of pain is assumed and treated proactively
# Critical Care Pain Observation Tool (CPOT)

Used for adults who are unable to communicate. Total score 0 to 8

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial expression</strong></td>
<td>• No muscular tension observed</td>
<td>Relaxed, neutral</td>
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<tr>
<td></td>
<td>• Presence of frowning, brow lowering, orbit tightening, and levator</td>
<td>Tense:</td>
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<tr>
<td></td>
<td>contraction</td>
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<tr>
<td></td>
<td>• All of the above facial movements plus eyelid tightly closed</td>
<td>Grimacing:</td>
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<tr>
<td><strong>Body movements</strong></td>
<td>• Does not move at all (does not necessarily mean absence of pain)</td>
<td>Absence of movements:</td>
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<tr>
<td></td>
<td>• Slow, cautious movements, touching or rubbing pain site, seeking</td>
<td>Protection:</td>
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<tr>
<td></td>
<td>attention through movements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulling tube, attempting to sit up, moving limbs/thrashing, not following</td>
<td>Restlessness:</td>
</tr>
<tr>
<td></td>
<td>commands, striking staff, trying to climb out of bed</td>
<td></td>
</tr>
<tr>
<td><strong>Muscle tension</strong></td>
<td>• No resistance to passive movements</td>
<td>Relaxed</td>
</tr>
<tr>
<td></td>
<td>• Resistance to passive movements</td>
<td>Tense, rigid</td>
</tr>
<tr>
<td></td>
<td>• Strong resistance to passive movements, inability to complete them</td>
<td>Very tense or rigid</td>
</tr>
<tr>
<td><strong>Compliance with ventilator</strong></td>
<td>• Alarms not activated, easy ventilation</td>
<td>Tolerating ventilator</td>
</tr>
<tr>
<td></td>
<td>• Alarms stop spontaneously</td>
<td>Coughing but tolerating</td>
</tr>
<tr>
<td></td>
<td>• Asynchrony: blocking ventilation, alarms frequently activated</td>
<td>Fighting ventilator</td>
</tr>
<tr>
<td>OR</td>
<td>• Talking in normal tone or no sound</td>
<td>Talking in normal tone</td>
</tr>
<tr>
<td></td>
<td>• Sighing, moaning</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td></td>
<td>• Crying out, sobbing</td>
<td>Crying out, sobbing</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FLACC Scale

• Used for pediatric patients 2 months to 7 years who are unable to communicate due to cognition or mechanical ventilation
• May be used in cognitively impaired, non-critical patients who are unable to communicate
• FLACC stands for
  - F – Face
  - L – Legs
  - A – Activity
  - C – Cry, Cry Face (Behavioral sign of pain to describe “cry’ in ventilated patients where facial expressions exhibit moaning or crying)
  - C – Consolability
• Each of the 5 categories is scored from 0-2, results in total score between 0 and 10
## FLACC Scale

### Categories Scoring

<table>
<thead>
<tr>
<th>Category</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FACE</strong></td>
<td>No particular expression of smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant quivering chin, clenched jaw</td>
<td></td>
</tr>
<tr>
<td><strong>LEGS</strong></td>
<td>Normal position or relaxes</td>
<td>Uneasy, restless, tense</td>
<td>Kicking, or legs drawn up</td>
<td></td>
</tr>
<tr>
<td><strong>ACTIVITY</strong></td>
<td>Lying, quietly, normal position, moves easily</td>
<td>Squirming, shifting back and forth, tense</td>
<td>Arched, rigid or jerking</td>
<td></td>
</tr>
<tr>
<td><strong>CRY/CRY FACE</strong></td>
<td>No cry (awake or asleep)</td>
<td>Moans or whimpers; occasional complaint</td>
<td>Crying steadily, screams or sobs, frequent complaints</td>
<td></td>
</tr>
<tr>
<td><strong>CONSOLABILITY</strong></td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging or being talked to, distractible</td>
<td>Difficult to console or comfort</td>
<td></td>
</tr>
</tbody>
</table>

### Totals
### N-PASS:
Neonatal Pain, Agitation, and Sedation Scale

- Used for neonates less than 44 weeks post-conceptual age
- Sedation creates a negative number and Pain creates a positive number.
- Range would be -10 to +10, but pain would be reflected by scores from 1 to 10

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Sedation</th>
<th>Normal</th>
<th>Pain / Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Criteria</strong></td>
<td>-2</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Crying Irritability</strong></td>
<td>No cry with painful stimuli</td>
<td>Moans or cries minimally with painful stimuli</td>
<td>Appropriate crying Not irritable</td>
</tr>
<tr>
<td><strong>Behavior State</strong></td>
<td>No arousal to any stimuli</td>
<td>Arouses minimally to stimuli</td>
<td>Appropriate for gestational age</td>
</tr>
<tr>
<td><strong>Facial Expression</strong></td>
<td>Mouth is lax No expression</td>
<td>Minimal expression with stimuli</td>
<td>Relaxed Appropriate</td>
</tr>
<tr>
<td><strong>Extremities Tone</strong></td>
<td>No grasp reflex Flaccid tone</td>
<td>Weak grasp reflex ↓ muscle tone</td>
<td>Relaxed hands and feet Normal tone</td>
</tr>
<tr>
<td><strong>Vital Signs</strong></td>
<td>No variability with stimuli Hypoventilatior or apnea</td>
<td>&lt; 10% variability from baseline with stimuli</td>
<td>Within baseline or normal for gestational age</td>
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</tbody>
</table>

- High-pitched or silent-continuous cry
- Inconsolable
- Arching, kicking
- Constantly awake or
- Arouses minimally / no movement (not sedated)
CPOE Equivalents

• When ordering and administering medications:
  Based on 0-10 rating scales:
  – Mild pain is equivalent to rating scale of 1-3
  – Moderate pain is equivalent to rating scale of 4-6
  – Severe pain is equivalent to rating scale of 7-10

Based on 0-8 (CPOT) rating scale:
  – Mild pain is equivalent to 1-3
  – Moderate pain is equivalent to 4-5
  – Severe pain is equivalent to 6-8
Reassessment of Pain

- Reassess pain using same rating scale on a regular basis and as needed following pharmacological or nonpharmacological interventions.
- Licensed staff will reassess pain within 60 minutes of pain relieving intervention: oral, IV, IM routes, physical agents, or repositioning.
- Reassess pain for transdermal route 24 hours after initial placement.
- Reassess pain for implantable pumps 5 minutes following change in dosage.
- For patients on Patient Controlled Analgesia and Epidural pumps, refer to PCA policy #400.031 and Epidural policy #400.036.