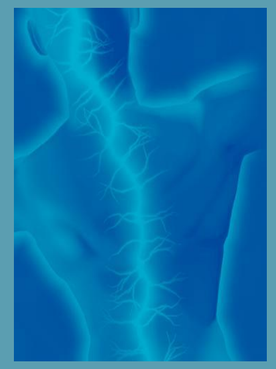
Foundations of Safe and Effective Pain Management

Evidence-based Education for Nurses, 2018

Module 1: The Multi-dimensional Nature of Pain

Module 2: Pain Assessment and Documentation

Module 3: Management of Pain and Special Populations



Adapted from: Core Competencies for Pain Management: Results of an Inter--professional Consensus Summit: Pain Med 2013; 14(7) 971-981

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Module 2: Pain Assessment and Documentation
Objectives

a. Understand the multidimensional features of pain assessment.
b. Use valid and reliable tools for assessing pain and associated symptoms.
    - Initial Screening
    - Ongoing Assessments (Including Discharge Assessment)
c. Assist patients in setting realistic acceptable pain intensity levels.
d. Identify tools for assessing acute and persistent pain and for patients unable to self-report pain.
e. Discuss the importance of empathic and compassionate communication during pain assessment.
f. Discuss the inclusion of patient and others, in the education and shared decision-making process for pain care.

Patient Screening, Assessment and Management of Pain (Policy and Procedure #30327.99)

A. Perform a Pain Screening during the initial assessment
    - Determine the presence of pain or history of persistent pain.
    - Identify whether the patient is opioid tolerant.

B. Perform an Initial Comprehensive Pain Assessment if the Initial Pain Screening indicates pain.

C. Perform Pain Screening at a frequency determined by individual patient need with consideration of patient's condition, history, risks and treatment or procedures likely to cause pain.

(Note: Assessing pain as the 5th Vital Sign is no longer a regulatory requirement)

A. Perform Ongoing Pain Assessment with any report of pain and as determined by individual patient clinical condition/need.

Tools for Measuring Pain and Associated Symptoms
Elements of Initial Pain Screening Upon Admission

- Intensity: *(new!)* Numeric Rating Scale, changing to Functional Pain Scale
- Location, origin, cause
- Acceptable pain intensity
- Pattern, onset, duration and quality
- Effects on function (ask patient for an example)
- Radiation characteristics
- Factors that alleviate or aggravate the pain
- Pain management regimen, effectiveness & intervention side effects

Pain Assessment

Pain Location/Description

	Pain Intensity	Location	Acceptable Pain Intensity	Time Pattern	Onset	Duration	Quality	Radiation Characteristics
Pain #1		<MultiAlpha>	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	
Pain #2		<MultiAlpha>	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	
Pain #3		<MultiAlpha>	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	

Pain Associated Factors

	Pain Associated Factors	Pain Associated Symptoms
Pain #1	<MultiAlpha>	<MultiAlpha>
Pain #2	<MultiAlpha>	<MultiAlpha>
Pain #3	<MultiAlpha>	<MultiAlpha>

Pain Intervention/Responses

	Pain Intervention: Adult	Post Intervention Assessment	Intervention Side Effects
Pain #1	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>
Pain #2	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>
Pain #3	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>

Tools for Measuring Pain and Associated Symptoms

Setting Realistic Expectations for Acceptable Pain Level

- Explain “Acceptable” and focus on improved <u>function</u>
- <u>A Scripted Example of Key Words at Key Times:</u>

Nurse: *What is your Acceptable Pain Level?*

Patient: *“0 out of 10”.*

Nurse: *“Zero is the absence of pain. While we do everything we can to reduce your pain level as low as possible, we may not be able to completely eliminate your pain.*

An acceptable level of pain means the amount of pain:

- *that you are able to experience without being in distress*
- *you can tolerate that does not affect your ability to function in an important way such as deep breathing, coughing or walking.*

“With those ideas in mind, what is your acceptable pain level?”

Key take away: The goal should be tolerable pain that allows the patient to perform important functions such as coughing and moving.

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Tools for Measuring Pain and Associated Symptoms
Expectations for the Frequency of Assessment / Reassessment

CAUTION: Reassessments done too early or too late may result in suboptimal pain management or a delay in recognizing over-sedation and respiratory depression.

- Assess pain and sedation prior to administration of any opioid
- Reassess based upon analgesic route, dose, and risk factors:

  As a general rule:
  - IV/ intranasal/buccal = within 10-30 min
  - PO / IM / SC / rectal = within 45-60 min
  - Transdermal patch = within 12 hours and every shift
    - Note: some patches may take 5-6 days to reach a steady state so for those first days, the patient's opioid level is gradually rising!

Tools for Measuring Pain and Associated Symptoms
Ongoing Assessment

Utilize the same principles of the initial assessment.

There are a variety of tools used at Sharp to evaluate the changing nature of the pain and evaluate effectiveness of interventions:

1) Numeric Rating Scale (NRS),
   is changing to a Functional Pain Rating Scale
   Used for most adults

2) Behavioral Indicator Scales:
   Used for non-verbal and/or cognitively impaired
   - **a) Pain Assessment in Advanced Dementia (PAINAD)**
     - Used in Non-ICU and ED
   - **b) Critical Care Pain Observation Tool (CPOT)**
     - Used only in ICU and ED

Herr, K., Coyne, P. J., Key, T., Manworren, R., McCaffery, M., Merkel, S., ... & Wild, L. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. *Pain Management Nursing*, *7*(2), 44-52.

Tools for Measuring Pain and Associated Symptoms

Aligning Functional Pain Rating with 'Mild, Moderate, Severe'

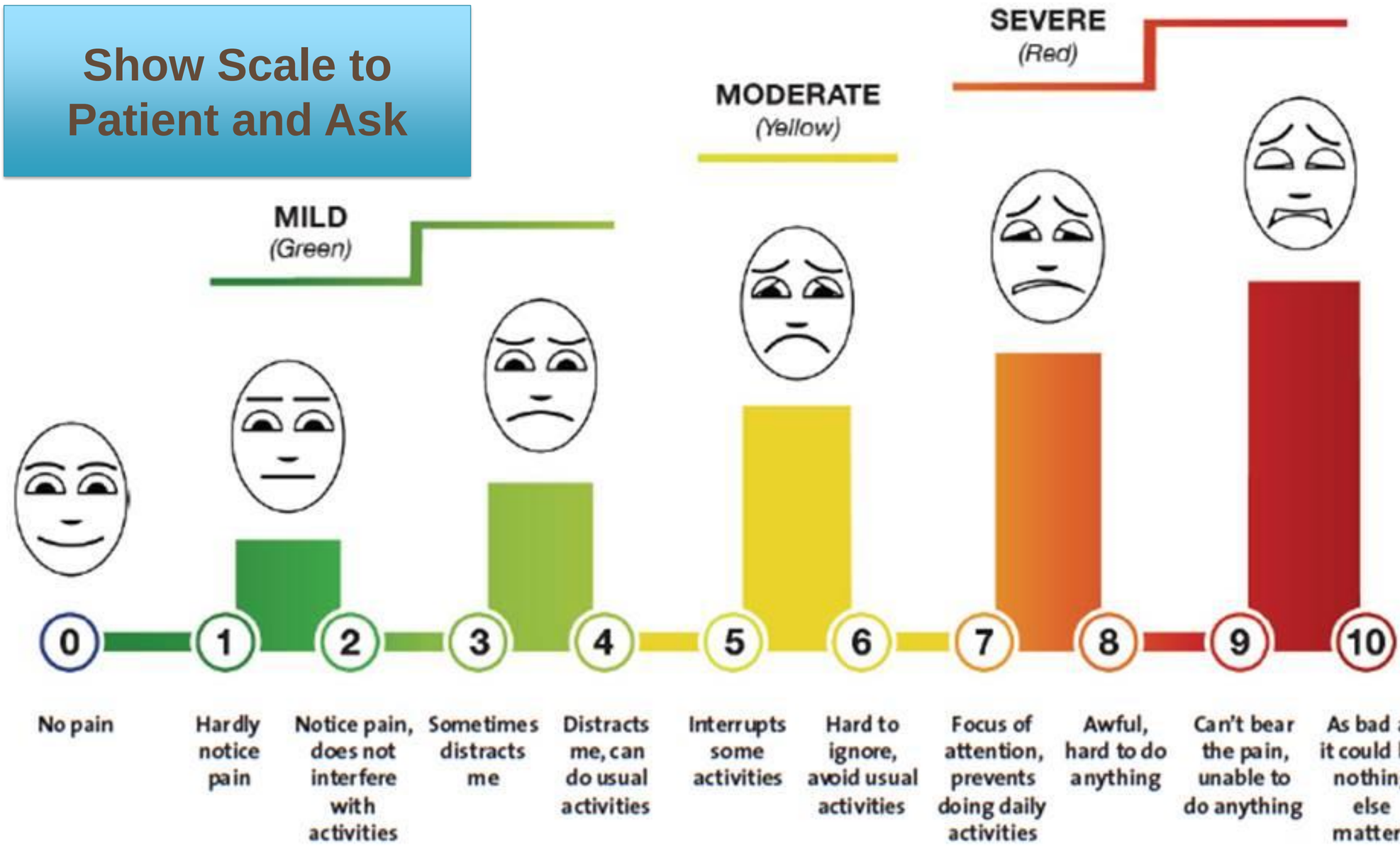
Numeric Scale / Functional Pain Rating ***NEW for Sharp Healthcare!*** A numerical rating based on the patient's ability to perform daily activities	
No Pain	**0** = No Pain
Mild pain = 1-3 rating	**1** = Hardly notice pain **2** = May notice pain but does not interfere with activities **3** = Sometimes distracts me
Moderate pain = 4-6 rating	**4** = Distracted by pain but can do usual activities **5** = Pain may interrupt some activities **6** = Hard to ignore, avoid usual activities
Severe pain = 7-10 rating	**7** = Focus of attention, prevents doing daily activities **8** = Awful, hard to do anything **9** = Can't bear the pain, unable to do anything **10** = As bad as it could be, nothing else matters
Behavioral Indicator Scales: (Used for non-verbal and/or cognitively impaired) **(PAINAD)** Pain Assessment in Advanced Dementia (For non- ICU and ED areas) **(CPOT)** Critical Care Pain Observation Tool (For only in ICU and ED) ***** Acceptable level of pain cannot be obtained with non-verbal patients!**	

Buckenmaier; C.; Galloway, K. T.; Polomano, R. C.; McDuffie, M.; Kwon, N.; Gallagher, R. M. (2013). Preliminary Validation of the Defense and Veterans Pain Rating Scale (DVPRS) in a Military Population. Pain Medicine, 14, 110-123.

Please look at the following pain scale, and circle the number on the rating scale below that best represents the amount or degree of pain you are having right now.

Functional Pain Rating Scale

Show Scale to Patient and Ask



v 2.0

Buckenmaier; C.; et al 2013).

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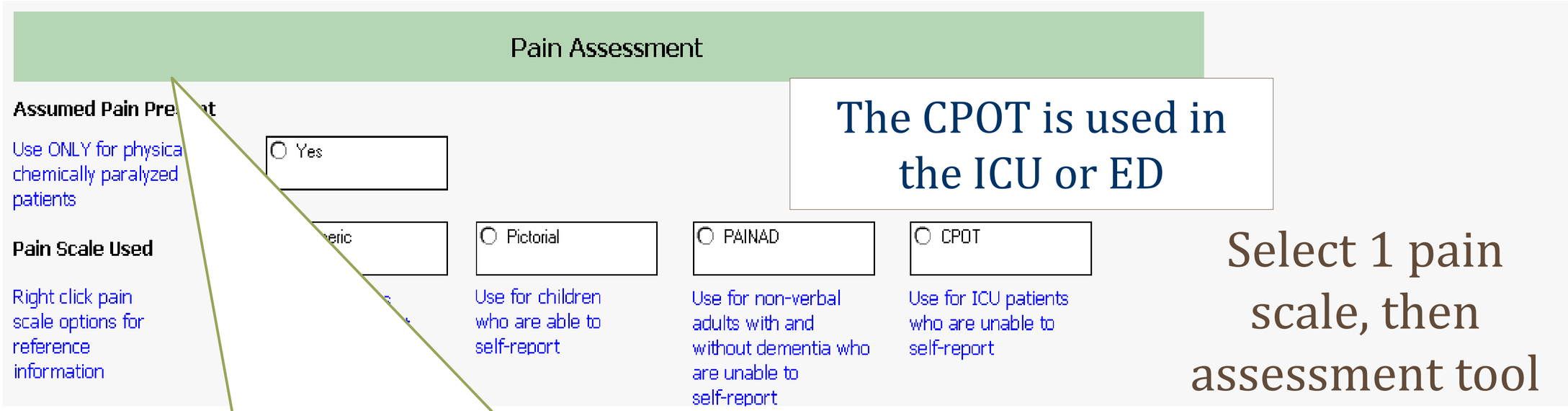
Tools for Measuring Pain and Associated Symptoms
Documenting your pain assessment

- In Ad Hoc…



The CPOT is used in the ICU or ED

Select 1 pain scale, then assessment tool will open…

NEW – Coming Soon:

Functional Assessment to be added here!

Challenge Question

A patient has a functional pain rating scale of 4. He is distracted by the pain but is able to mobilize, cough and take deep breaths. The patient states that 4 is his acceptable pain intensity. The patient has 0.5 mg dilaudid IV prn ordered for moderate pain. Which of the following would be the best course of action for the nurse:

A. Give 0.5mg dilaudid IV to keep the pain in control
B. Encourage the patient to continue mobilization and deep breathing, and report any worsening pain
C. Educate the patient about the hazards of pain and the low risk of opioid addiction
D. Call the physician and request an oral route for an opioid

Challenge Question

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Answer: B

Rationale: If a patient is experiencing pain which is at their acceptable pain level and are able to perform necessary functions, opioids are unnecessary and may cause unintended side effects

Tools for Measuring Pain and Associated Symptoms
Nonverbal / Cognitively Impaired

- Observation of behavior is necessary to assess pain in adults who cannot self report

- Behaviors can only be assessed in patients able to exhibit them, i.e. ***not*** paralyzed (physiologically or pharmacologically)
- If unable to assess behavior in a non-verbal patient, assess for the presence of a painful condition or procedure known to cause pain, ***assume pain is present***, & provide pain relief interventions
- *Acceptable level of pain is not obtainable in non-verbal patients*

Pasero, C., Quinlan-Colwell, A., Rae, D., Broglio, K., & Drew, D. (2016). American Society for Pain Management Nursing position statement: Prescribing and administering opioid doses based solely on pain intensity. Pain Management Nursing, 17(3), 170-180.

Tools for Measuring Pain and Associated Symptoms:
The Pain Assessment in Advanced Dementia (PAINAD)
Used in Non-ICU/ED Areas for Nonverbal/Cognitively Impaired Patients

Observe with activity or movement and assign points in each of the categories
***Nonverbal pain* scores do not crosswalk to Numerical Rating Scale**

Items	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low level speech with negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad, frightened or frown	Facial grimacing	
Body language	Relaxed	Tense, distressed pacing or fidgeting	Rigid, fists clenched, knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure.	
			Total Score	

Tools for Measuring Pain and Associated Symptoms

Documenting your pain assessment

PAINAD Assessment in Ad Hoc

Pain Assessment in Advanced Dementia (PAINAD)

For use in non-verbal adults with or without dementia who are unable to self-report

PAINAD - Breathing
- (●) Normal (0)
- ( ) Occasional labored breathing. Short periods of hyperventilation. (1)
- ( ) Noisy labored breathing. Long periods of hyperventilation. Cheyne-Stokes respirations. (2)

PAINAD - Vocalization
- ( ) None (0)
- ( ) Occasional moan or groan. Low level speech with negative or disapproving quality. (1)
- ( ) Repeated troubled calling out. Loud moaning or groaning. Crying. (2)

PAINAD - Facial Expression
- ( ) Smiling or inexpressive (0)
- ( ) Sad, frightened or frown (1)
- ( ) Facial grimacing (2)

PAINAD - Body Language
- ( ) Relaxed (0)
- ( ) Tense, distressed pacing or fidgeting (1)
- ( ) Rigid fists, clenched, knees pulled up. Pulling or pushing away. Striking out. (2)

PAINAD - Consolability
- ( ) No need to console (0)
- ( ) Distracted or reassured by voice or touch (1)
- ( ) Unable to console, distract or reassure (2)

PAINAD - Total Score [ ]

Put total PAINAD score into Pain Assessment grid under Pain Intensity

MILD pain = total score of 1-3
MODERATE pain = total score of 4-6
SEVERE pain = total score of 7 or above

Place total PAINAD score into Pain Intensity field

PAINAD In Interactive View… Click on Blue Text to open scale

Pain Assessment		
Assumed Pain Present(only paralyzed pts)		
Pain Scale Used - Numeric		
Pain Scale Used - Pictorial		
Pain Scale Used - PAINAD		PAINAD
PAINAD Pain Scale		
PAINAD - Breathing		Occasio…
PAINAD - Vocalization		Occasio…
PAINAD - Facial Expression		Facial gri…
PAINAD - Body Language		Relaxed…
PAINAD - Consolability		No need…
PAINAD - Total Score		4
Pain Scale Used - CPOT		
Pain #1		
Pain #1 Intensity		4
Pain #1 Location		Right, Arm
Pain #1 Acceptable Pain Intensit		3 - Mild
Pain #1 Time Pattern		Acute
Pain #1 Onset		Gradual
Pain #1 Duration		3 hrs
Pain #1 Quality		Aching
Pain #1 Radiation Characteristics		
Pain #1 Associated Factors		No obvi…
Pain #1 Associated Symptoms		
Pain #1 Interventions		
Pain #1 Post Intervention Assessment		
Pain #1 Intervention Side Effects		

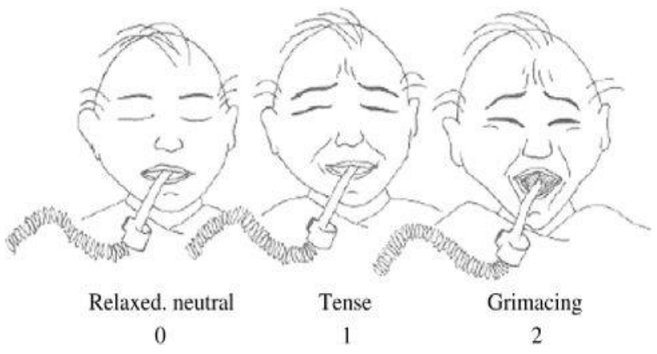
Transfer Total Score into Pain Intensity

Tools for Measuring Pain and Associated Symptoms

The Critical Care Pain Observation Tool (CPOT)

Used in ICU/ED/PACU for Nonverbal / Cognitively Impaired Patients

- Nonverbal pain scores do not crosswalk to Numerical Rating Scale
- Evaluate at rest for a baseline, then with movement
- Maximum score is 8; *Score of 2 or greater requires intervention*

Indicator	Score		Description
Facial Expression 	Relaxed, Neutral	0	No muscle tension observed
	Tense	1	Presence of frowning, brow lowering, orbit tightening, and levator contraction
	Grimacing	2	All of the above facial movements plus eyelid tightly closed
Body Movements	Absence of movements	0	Does not move at all (does not necessarily mean absence of pain)
	Protection	1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness	2	Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed

Critical Care Pain Observation Tool (CPOT) cont.

Compliance with the ventilator **Intubated patients** ***OR***	Tolerating ventilator or movement	0	Alarms not activated, easy ventilation
	Coughing but tolerating	1	Coughing, alarms activated, but stop spontaneously
	Fighting ventilator	2	Asynchrony, blocking ventilation, alarms frequently activated
Vocalization **Extubated patients**	Talking in normal tone or no sound	0	Talking in normal tone or no sound
	Sighing, moaning	1	Sighing, moaning
	Crying out, sobbing	2	Crying out, sobbing
Muscle Tension **Evaluate by passive flexion and extension of upper limbs when patient at rest**	Relaxed	0	No resistance to passive movements
	Tense, rigid	1	Resistance to passive movements
	Very tense, rigid	2	Strong resistance to passive movements, inability to complete them
	Score:	**__** ***A CPOT ≥2 requires intervention***	**Target Pain 0-1**

Click on this link to watch a 13 min video demonstration of the CPOT

http://pointers.audiovideoweb.com/stcasx/il83win10115/CPOT2011-wmv.wmv/play.asx

Tools for Measuring Pain and Associated Symptoms
Translating Pain Rating to Pain Level for Analgesic Dose

<u>Numeric, Functional Pain Rating and PAINAD</u>

- Analgesic dosing orders correspond to level of pain
- Alternating between numeric rating and CPOT may be necessary depending upon the patient's current responsiveness
- Remember: Do not document an "acceptable pain level" when a patient is cognitively impaired / non-verbal.

Empathetic Pain Assessment Techniques
A Motivational Interviewing Approach

- Motivational interviewing is a method that helps people find the internal motivation they need to change their behavior. It is a practical and empathic process that considers how difficult it is to make life changes.
- Ask about their own reasons for wanting to change
- Have a mindset of adherence to therapies (instead of compliance to)
  - *Compliance has a tone of judgment, persuasion, confrontation*
  - *Adherence has a tone of discovering the patient's internal motivation*
    - *Eg. "What option for pain control are you most likely to use?"*
- See next slide for examples of motivational interviewing questions.
- In general:
  - Ask Open-ended questions
  - Listen without judgment or interruption
  - Summarize by reflecting the patient's words

Alperstein & Sharpe, 2016

Nurse Coaching for Barriers to Pain Management

Nurse Coaching Steps	Pain Beliefs	Communication	Medications	Nonpharmacologic Interventions
Current Issue	Why do you think you have pain? What is causing your pain? What are your beliefs about the causes of your pain? Is anything preventing you from controlling your pain?	Do you choose not to discuss pain or discomfort? What prevents you from talking with your nurse?	Do you have concerns about your pain medications? Are you afraid of becoming addicted to your pain medications? Would you rather deal with pain than the side effects of your pain medications?	Do you think other options are available to treat your pain? Have you tried treatments other than medications for controlling pain? (adjunctive treatments) If not, what stops you from trying these other options?
Problem impact	How would understanding the causes of your pain affect the level of your pain, your ability to function, and your quality of life? What are the best and worst possible outcomes?	How would more effective communication influence the level of your pain, your ability to function, and your quality of life? What are the best and worst possible outcomes?	How would using a variety of medications affect the level of your pain, your ability to function, and your quality of life? What are the best and worst possible outcomes?	How would using or not using nonmedical strategies affect the level of your pain? What are the best and worst possible outcomes?
Strategies	What option for controlling pain are you most likely to use? How do you control your pain at home? How will this option help you better control pain, increase functioning, and improve the quality of your life?			

Fahey et al., 2008 .

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Patient/Care Giver Education and Shared Decision-making for Pain Care

Key points to include in patient education:

- How to use the pain scale and set realistic expectations
- Side effects, interactions, risks and benefits of pain management options
- Rationale for frequent monitoring including the need to be awakened to assess sedation level
- To alert staff for breathing problems or other reactions

Discharge Education:

  - Please refer to Cerner Depart Process (Exit Care) for patient education materials re: “What you Need to Know About Prescription Opioid Pain Medicine”
  - Consult Social Work for community resources as needed

Challenge Question:

Nancy RN is educating her patient about pain medicine. What would you have her discuss with the patient at the beginning of her instruction? Select all that apply.

a. What does the patient do at home for pain relief and is it effective?
b. What we can offer to go along with the pain medicine (hot/cold, aromatherapy, mindfulness, meditation, guided imagery)
c. At what level of pain can the person walk, eat, etc.
d. Past history of pain, medicines, success or failure
e. Fears about the opioid crisis in America and addiction

Challenge Question:

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c. At what level of pain can the person walk, eat, etc.
d. Past history of pain, medicines, success or failure
e. Fears about the opioid crisis in America and addiction

Key: All of the above

Summary of Key Points

- **Optimal assessment of pain requires more than just a pain intensity score.**
- **Coach patients in setting realistic pain intensity levels.**
- **Help patients rate their pain according to the effect of pain on their ability to function.**
- **Accurate and timely assessment of pain is essential for effective pain management.**
- **When a patient cannot participate in the assessment process, then valid and reliable tools designed for observation of pain behaviors in specific populations should be used.**

Author Information and References

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Patty Atkins

2018

For references and other resources, please visit:

http://sharpnet.sharp.com/pharmacy/Pain-Management.cfm

Exit

- Click the “X” (close button) in the upper right hand corner of the screen when you are ready to complete the requirements for this course.