

PRINCIPLES OF PAIN ASSESSMENT

Rationale

This guideline is adapted for inter-professional primary care providers working in various settings in VIHA and any other clinical practice setting in which a user may see the guidelines as applicable.

Pain is consistently experienced as a moderate or severe symptom in cancer patients. Studies indicate patients with metastatic cancer frequently identify pain as a symptom ⁽¹⁾ and that the prevalence of moderate or severe pain increases in late stages of cancer^(1,2)

Scope

This guideline provides recommendations for the assessment and symptom management of adult patients (age 19 years and older) living with advanced life threatening illness and experiencing pain. This guideline does not address disease specific approaches in the management of pain.

Definition of Terms

Pain is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage” ⁽³⁾

The concept of **Total pain** encompasses the multidimensional factors that contribute to the patients experience of pain. It may include all of the following: Intellectual Pain, Emotional Pain, Interpersonal Pain, Financial Pain, Spiritual Pain, Bureaucratic Pain, and Physical Pain.⁽⁴⁾ The patient’s experience of pain is expressed within the context of the illness, and the personal, emotional, social, cultural, and spiritual orientation of the individual. Suffering, like pain, is subjective. Suffering is characterized as a person’s evaluation of the significance of an event such as pain - or the meaning of an event in relationship to self and to the quality of life.

“Pain is what the patient says it is, and exists whenever the patient says it does.”⁽⁴⁾

Standard of Care

1. Assessment
2. Classification
3. Establish a Plan
4. Education

Recommendation 1

Assessment of Pain

Ongoing comprehensive assessment is the foundation of effective pain management, including interview, physical assessment, medication review, medical and surgical review, psychosocial review, review of physical environment and the appropriate diagnostics. ⁽⁵⁾ (see Table 1). Assessment must determine the cause, effectiveness of treatments and impact on quality of life for the patient and their family.

Table 1: Pain Assessment using Acronym O, P, Q, R, S, T, U and V*

O Onset	When did it begin? How long does it last? How often does it occur?
P Provoking / Palliating	What brings it on? What makes it better? What makes it worse?
Q Quality	What does it feel like? Can you describe it?
R Region / Radiation	Where is it? Does it spread anywhere?
S Severity	What is the intensity of this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Right now? At best? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
T Treatment	What medications and treatments are you currently using? How effective are these? Do you have any side effects from the medications and treatments? What medications and treatments have you used in the past?
U Understanding/ Impact on You	What do you believe is causing this symptom? How is this symptom affecting you and / or your family?
V Values	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom (On a scale of 0 to 10 with 0 being none and 10 being worst possible)? Are there any other views or feelings about this symptom that are important to you or your family?

***also include a Physical Assessment (as appropriate for symptom)**

- **Goal of Pain Assessment**
 - to capture the individual's pain experience in a standardized way
 - to help determine type of pain and possible etiology
 - to determine the effect and impact the pain experience has on the individual and their ability to function.
 - basis on which to develop treatment plan to manage pain
 - to aid communication between interdisciplinary team members.
- **Self reporting** should be the primary source of information when completing a pain assessment. Trust the client's assessment of pain. Lack of pain expression does not necessarily mean absence of pain. ⁽⁸⁾
- The exception for patient self-reporting is with non-verbal, non-cognizant persons (ie. the cognitively impaired) For these populations, behavioral observations that are validated by family and caregivers are the primary source of information for a pain assessment. For the cognitively impaired patient, use the Abbey Pain Assessment (*see Appendix A*) and/or a visual or faces pain scale instead of verbal questions.⁽⁴⁾ Body language should also be observed: facial expressions, verbalizations, behaviour during activity, movements and gestures. ⁽⁸⁾
- In the cognitively impaired recognize pain as a possible cause of changes in function or behaviour: increased confusion, resistance to care, disruptive behaviour, aggression, changes in appetite, changes in sleep pattern, asking for help, reduced mobility, social withdrawal.
- Screen all persons at risk for pain. Pain assessment should be completed by the primary care provider on admission to all sites/programs and reassessed *on an ongoing basis* ⁽⁴⁾ as there is always the potential for new or increasing symptoms as the patient nears the end of life.
- Once the presence of pain has been identified an initial comprehensive pain history must be completed. Use a validated measurement tool, such as the OPQRSTUV above, to ensure that complete, comprehensive, and consistent assessments are done (*see Appendix B*) .
- When pain is identified in more than one site, an assessment is completed for each site. ⁽⁸⁾
- A comprehensive pain assessment should be re-done if there is a significant change in the pain, any modification to the pain management plan, or if a new pain has been identified.
- Following analgesic administration, the assessment of pain severity on a scale of 0-10 using a pain scale would be the *minimum* assessment to be completed to monitor analgesic effectiveness in meeting patient's goal. Use a standard pain scale matched to the patient's cognitive and communication abilities ie. Visual Analogue Scale (VAS), Numeric Rating Scale (NRS 0-10), Faces Scale, or Verbal Scale. ⁽⁸⁾
- Pain assessments should be documented so that all members of the care team will have a clear understanding of the pain. Location of documentation to be consistent within each care site (*see Appendix C*).

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- When efforts of the primary care providers do not relieve pain, a team conference (including patient and/or family) should be held. A referral to the Hospice Palliative Team should be made, if available, or consult with a palliative care physician or the VIHA Pain Program.

Recommendation 2

Classification of Pain

Pain is classified by mode of origin and transmission to aid in choosing a management plan for pain relief ^(3,5)

Nociceptive pain is due to the stimulation of nerve fibers that transmit signals in a *normal* way from nerve endings to brain centers. ⁽⁵⁾

- **Somatic pain** – pain originating from muscle, soft tissue or bone. It is usually well localized and described as deep, aching, or boring. It may be worse with movement. Some examples are bone metastases, osteoarthritis, and muscle/tissue damage. ^(5,7)
- **Visceral pain** – pain originating from internal organs or viscera surrounding them. It is usually less well localized and can be referred. Often described as deep aching, cramping, or squeezing. Some examples are bowel obstruction, brain tumour, and appendicitis. ^(5,7)

Neuropathic pain is the *abnormal sustained* stimulation of the nerve fibers that transmit signals from the nerve ending to brain center and/or from a dysfunction in the central nervous system. ⁽⁷⁾

- It can be **dysesthetic** pain – described as burning, electrical sensations or pins and needles and/or **lancinating** pain – described as stabbing, shooting, or hot poker ⁽⁷⁾
- Some examples are post-herpetic neuralgia, spinal cord compression, diabetic neuropathy, plexopathies, phantom limb, or central pain from a stroke
- Pain may exceed any observable injury and often requires multiple medications to obtain relief (See recommendation 14 in *VIHA End of Life Symptom Guidelines for Principles of Pain Management*)

Recommendation 3

Establish a Plan

Using the pain assessment establish a plan that:

- uses the most effective pharmacological and non-pharmacological interventions for the type of pain identified (see *VIHA End of Life Symptom Guidelines for Principles of Pain Management, recommendations 14 & 15*)
- includes physical, psychological, and behavioral interventions
- includes treatments and selection of analgesia/adjuvants which are individualized and consistent with the patients goals for pain relief. These goals may also relate to:
 - maintenance of dignity ⁽⁸⁾
 - acceptable functional capacity ⁽⁸⁾
 - quality of life ⁽⁸⁾

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- capacity for adequate rest and sleep ⁽⁸⁾
- medication side effects minimal or at least tolerable ⁽⁸⁾

Assess and document the effectiveness of the plan on an ongoing basis. ⁽⁸⁾

Recommendation 4

Education

- It is important to explain to the patient and family that pain *may* get worse as the disease progresses; however, there are many options available for pain relief.
- Discuss the concept of pain prevention with the patient and family, in an effort to lessen the pain experience before pain becomes difficult to manage.
- Teach patients and families to report changes in pain, pain that is new, and pain that does not improve after intervention.
- Some patients, particularly the elderly, may underreport pain because they:
 - Have not been taken seriously in the past ⁽⁵⁾
 - fear being labeled a “complainer” ⁽⁸⁾
 - want to appear stoic, an important characteristic in some cultures ⁽⁵⁾
 - expect pain with aging, when in fact it is common but not a normal part of aging ⁽⁸⁾
 - choose to avoid medications and side effects ⁽⁸⁾

Education for patient and family should occur regarding these concerns to ensure they report their pain in a trusting and caring environment.

- Include the patient and family in decision making to determine a care plan that values the patients wishes, emphasizing the shared goals of care.

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References

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APPENDIX A

ABBAY PAIN SCALE

For measurement of pain in people with dementia who cannot verbalize.

How to use scale: While observing the resident¹ score questions 1 to 6

Name of resident:.....

Name and designation of person completing the scale:.....

Date: **Time:**

Latest pain relief given was **at**.....**hrs.**

- Q1. Vocalization**
 eg. **Whimpering, groaning, crying**
 Absent 0 Mild 1 Moderate 2 Severe 3

Q1
- Q2. Facial expression**
 eg: **looking tense, frowning, grimacing, looking look frightened**
 Absent 0 Mild 1 Moderate 2 Severe 3

Q2
- Q3. Change in body language**
 eg: **fidgeting, rocking, guarding part of body, withdrawn**
 Absent 0 Mild 1 Moderate 2 Severe 3

Q3
- Q4. Behavioural Change**
 eg: **increased confusion, refusing to eat, alteration in usual patterns**
 Absent 0 Mild 1 Moderate 2 Severe 3

Q4
- Q5. Physiological change**
 eg: **temperature, pulse or blood pressure outside normal limits, perspiring, flusing or pallor**
 Absent 0 Mild 1 Moderate 2 Severe 3

Q5
- Q6. Physical changes**
 eg: **skin tears, pressure areas, arthritis, contractures, previous injuries.**
 Absent 0 Mild 1 Moderate 2 Severe 3

Q6

Add scores for 1 – 6 and record here **Total Pain Score**

Now tick the box that matches the Total Pain Score

0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe
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Finally, tick the box which matches the type of pain

Chronic	Acute	Acute on Chronic
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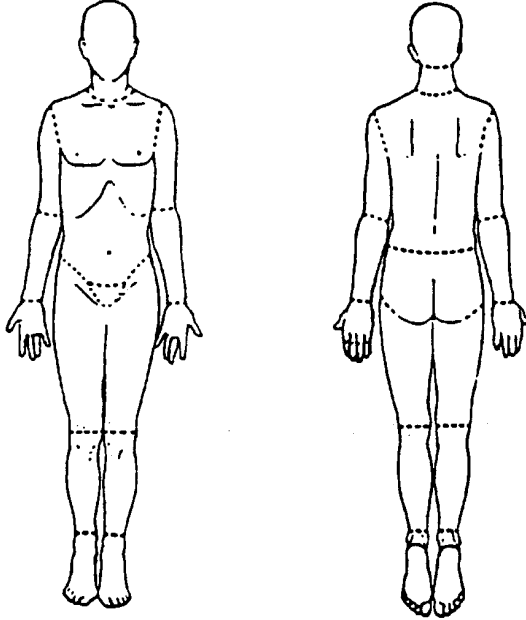
¹ Resident is used here but also refers to patient and client

APPENDIX B EXAMPLE OF A PAIN ASSESSMENT TOOL

Date: _____ Signature: _____ Discipline: _____

REASON FOR ASSESSMENT: Admission Change of condition other (e.g. regular review)

BODY MAP: Place a number (e.g. 1, 2, 3) on the body indicating the location of pain/discomfort; use 1 for worst pain and 2 for next pain, etc. in the order of how distressing each pain is.



**NON-VERBAL PAIN INDICATORS:
(Check as many as apply)**

- Verbally Excessive
- Moans/Sighs
- Weeps/Cries
- Cries out when moved
- Grimaces/Grunts
- Rubs body part
- Restless
- Rocks
- Guards
- Retracts
- Holds body part
- Fidgets
- Resistive to touch
- Lethargic

FACES/NUMERIC SCALE: Person indicates/states the pain/discomfort is **(CIRCLE ONE)**



(None)	Mild		Moderate		Extreme					
0	1	2	3	4	5	6	7	8	9	10

WORDS THE PERSON USES TO DESCRIBE THE PAIN/DISCOMFORT:

- Discomfort
- Pins and Needles
- Shooting
- Constant
- Dull ache
- Stabbing
- Electric Like
- Occasional
- Sharp
- Cramping
- Surface
- Other _____
- Burning
- Throbbing
- Deep

HAS THE PAIN/DISCOMFORT OR TREATMENT PRODUCED ANY OTHER SYMPTOMS?

- Nausea
- Drowsiness
- Change in mood
- Loss of Appetite
- Dizziness
- Disturbed sleep
- Diarrhea
- Unclear thinking
- Other _____
- Constipation
- Anxiety

Character of Pain / Discomfort (OPQRSTUV)

O - Onset When did it start? Time of day _____

P – Pattern/Place Duration & triggers _____

Q - Quality How it affects you / others (physically & socially) _____

R - Relieving / Aggravating factors (What do you do to relieve the discomfort?)

S - Sleep/Severity (Can you go to sleep? Does the pain/discomfort affect your sleep? Do you wake with discomfort/pain? _____

T - Treatment (What have you tried? What has worked? Not worked? E.g. medications, heat, other therapies) _____

U - Understanding (What do you understand about this pain? What does having this 'pain' 'discomfort' mean for you? _____

V - Values/Concerns (What do you hope / expect in relation to this pain/discomfort?)

Other comments (include comments from family, friends)

Goal: (What would you like to see happen in relation to the pain/discomfort? E.g. pain free, tolerable, able to sleep at night, etc)

Recommended interventions and time frame:

Signature: _____ Date: _____