PRINCIPLES OF PAIN MANAGEMENT: BEDSIDE NURSING ASSESSMENT TOOL

Assessment and Diagnosis

"Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does." (McCaffery, 1999)

History & Comprehensive Assessment

- Onset, location, quality, intensity, temporal pattern, aggravating and alleviating factors, associated symptoms
- Characteristics of pain
  Somatic pain: localized; ache, throb, or gnaw
  Visceral pain: often referred; cramp, pressure, deep ache, squeeze
  Neuropathic pain: burns, electric shock, hot, stab, numb, itch, tingle
  Acute Pain: ↑HR, HBP, diaphoresis, pallor, fear, anxiety
  Chronic pain: sleep difficulties, loss of appetite, psychomotor retardation, depression, career/relationship change
- Underlying causes of pain to target treatment
- Impact of pain on physical function (i.e. mobility, ADLs, impact on activities) and psychosocial function (i.e. depression, anxiety, sleep)
- Depression, anxiety, PTSD, sleep pattern, suicide risk
- Patient, family and caregiver's cultural and spiritual beliefs
- Pain coping skills
- Previous and current methods of treatment: effectiveness, adverse events, OTCs
- Other medical and surgical conditions
- Substance use and risk for misuse (e.g. Opioid Risk Tool- Revised)

Routine Assessment of Pain, Function & Quality of Life

- Evaluate pain on all patients using the 0-10 scale (Use Faces Pain Scale – Revised):
  A. mild pain: 1-3
  B. moderate: 4-7 (interferes with work or sleep)
  C. severe: 8-10 (interferes with all activities)
- Capture variation in pain severity at different sites of pain (Use Ransford Pain Drawing)
- Recognize pain varies at different times of day
- Capture the impact of pain on function & quality of life (Use PEG Scale: A Three-Item Scale Assessing Pain Intensity and Interference
- Ask the patient what matters most and personal goals for care

Treatment

Goals

- Based on patient values/preferences considering pain intensity, improved function, and cognitive function.
- Balance pain relief, improved function and adverse events
- Treat acute pain aggressively to avoid chronic pain
- Treat chronic pain thoughtfully and systematically
- Identify and address the cause of pain
- Intervene as noninvasively as possible

Active Approach

- Patient / Family Education
- Cognitive Behavioral Therapy; Supportive Psychotherapy
- Community & Web-based Support Groups
- Exercise: Yoga, Tai Chi, Qi Gong, Walking, Water Therapy
- Meditation, Mindful Practice; Visualization/Interactive Guided Imagery;
- Physical Therapy; Chiropractic/ Osteopathic Care
- Prayer, Spiritual & Pastoral Support
- Relaxation Techniques: Biofeedback,

Passive Approach

- Acupressure (trigger point therapy)
- Acupuncture (trigger point therapy)
- Cutaneous Stimulation: Ice, Heat; Counterstimulation: TENS
- Massage, Music, Hydrobath
- Manipulation/Manual Therapies
- Therapeutic Touch, Reiki, Healing Touch

Pharmacological Therapy

- Dispense medication as ordered using the 5 Rights: patient, drug, dose, route, time)
- Administer analgesics based on assessment of pain severity and available prescriptions
- Evaluate treatment effectiveness based on goal achievement and/or adverse events
- Communicate unrelieved pain or AE to PCP for changes in treatment plan

Anticipate side effects

- Prevent constipation: start senna, miralax
- Nausea: treat with antiemetics or change meds
- Pruritus: treat with antihistamines or change meds
- Mental impairment: avoid driving/hazardous situations until side effect profile stabilizes; reassess safety periodically

Management and Monitoring

General

- Reassess regularly for pain, pain relief & function
- Consistently use valid tools (i.e. numeric scale, face scale); respond urgently to severe pain ≥8
- Clearly document time medication is given and response to pain medication
- Assess mobility and ADL status
- Partner with patient/family in setting goals of care
- Balance function versus complete absence of pain

Special Situations

Anxiety and depression

- Provide emotional support
- Advocate for psychosocial consultation or analgesic management prn

Verbally non-communicative patients

- Cognitively impaired all feel pain but may not be able to communicate pain
- Infants, children feel pain – see Pediatric Guide
- Evaluate patient's behaviors related to discomfort such as grimacing, moaning/groaning, bracing, rubbing, guarding, crying, noisy breathing, grinding teeth, frightened facial expressions, tense, fidgeting, agitation, disruptive behavior
- Use valid and reliable nonverbal pain behavior tool appropriate to the population (e.g. PAINAD)
  Please Note: Similar findings are often seen in terminal restlessness.
- Autonomic changes in acute pain may be blunted in dementia

Older adults or people with renal or hepatic disease

- Watch carefully for toxicity from accumulation

Prevent opioid misuse/abuse

- Monitor for signs of misuse and/or abuse
- Encourage established functional goals
- Ensure follow-up and evaluation of treatment effectiveness

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Guidelines & principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines & principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care should be tailored to fit individual needs. Approved in June 2019; Next Scheduled Update in 2021

Pain Assessment in Advanced Dementia- PAINAD (Warden, Hurley, and Volicer, 2003) *

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 of speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense. Distressed pacing. 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*				

* Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

Instructions: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

Note: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and surrogate report from an individual knowledgeable of the person and their pain behaviors.

Remember that some patients may not demonstrate obvious pain behaviors or cues.

*** Please Note: Similar findings are often seen in terminal restlessness.**

Reference: Warden V, Hurley AC, and Volicer V. 2003. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *Journal of the American Medical Directors Association 4*(1): 9-15.

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