Eastern Health

SCREENING AND ASSESSMENT OF PAIN	General Therapeutics 204(NUR)-6-010

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Overview

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (IASP, 2012), It is multi-dimensional in nature with many causes. Pain is what the client says it is; it exists when the client says it does.

Assessing pain, intervening to ease it, monitoring, preventing and minimizing it should be top priorities of a person's care, regardless of their diagnosis or type of pain.

Nurses perform a comprehensive pain assessment on clients who have screened positive for having the presence of any type of pain using a systematic approach and appropriate tools.

Self-report is the most reliable method of pain assessment. Self-report is defined as the ability to communicate either verbally or non-verbally (blinking of eye, writing about one's pain). Not everyone is able to self-report pain. It is important to understand the inability to describe pain does not mean that a person is not experiencing it. Assessing pain in clients who are unable to express it is critical to appropriate care.

People who are unable to talk or self-report may include:

- Neonates, infants and preverbal children;

- Persons with cognitive impairment (such as advanced dementia);
- Persons with intellectual disability;
- Critically ill or unconscious persons; and
- Persons who are terminally ill (RNAO, 2013).

POLICY

1. In some practice settings and in some client populations, routine screening and assessment of pain is not required unless clinically relevant.

2. Screen for the presence of, or risk of, any type of pain:
    - On initial intake
    - After a change in client status; and
    - Prior to, during and after a procedure/intervention

Clients Who **Can** Self-Report:

3. Perform a baseline assessment using the acronym "PQRST" as a guide (See Attachment A).

4. For all subsequent assessments use the Numeric Rating Scale.

5. For children age 4 to 8 years use the Wong-Baker FACES Scale.

Clients Who **Cannot** Self Report:

There will be specific clients or populations where alternate pain assessment tools are required to properly assess pain (Refer to Guidelines Section for Samples). The use of these tools should be standardized to the practice or program setting.

6. The frequency of assessments will be determined by:
    - Presence of pain
    - Pain intensity
    - Client's medical condition
    - Type of pain (e.g. acute versus persistent)
    - Practice setting (e.g. post anesthesia recovery room versus community)
    - Specific protocols (e.g., epidural, chest pain)

7. Sudden changes in a client's report of pain, with or without changes in vital signs, should be assessed immediately.

Scope

Registered Nurses and Licensed Practical Nurses.

Purpose

To standardize the screening and assessment of pain by using a systematic approach and appropriate tools.

Guideline

1. Clients receiving medications for chronic pain management may require additional medications for acute pain.

2. Client education about pain management should include but not be limited to the following:
    - When to report pain.
    - Use of a pain rating scale
    - Treatment being used (pharmacologic versus non-pharmacologic)
    - Potential side effects (e.g. constipation with opioids)
    - Common misconceptions about pain management (e.g. addiction to opioids)

3. Documentation includes:
    - Assessment
    - Intervention performed
    - Client response.

4. A Sample of Recommended Tools for Clients Who Cannot Self-Report:

    - Pain Assessment in Advanced Dementia (PAINAD) for clients with advanced dementia.
    - Checklist of Nonverbal Pain Indicators (CNPI) for cognitively impaired adults post-operatively.
    - Premature Infant Pain Profile Pain Assessment Tool (PIPP) for preterm and term infants.
    - Revised FLACC for children aged 2 months to 8 years (but has been used in children 0-18 years) with procedural and postoperative pain.
    - Modified Comfort Scale for intubated children.

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- International Association for the Study of Pain (2012a). IASP Curriculum Outline on Pain for Nursing. Retrieved from http://www.iasp-pain.org
- Registered Nurses Association of Ontario. (2013). *Nursing best practice guideline: Assessment and management of pain. 3rd Ed.* Toronto, Ontario.
- Zwakhalen, S.M.G. et al. (2006). Pain in elderly people with severe dementia: A systematic review of behavioral assessment tools. BMC Geriatrics, 6(3), 1-15.

Linkages

- Personal Protective Equipment IPC-190
- Hand Hygiene Policy IPC-150.
- Positive Patient Identification Policy PRC-130
- Clinical Documentation PRC-020
- Infant Pain Assessment and Management 270CWH-NB-10
- Assessment of Acute Pain for Adult Inpatient Surgical Clients 220-PC-001

Key Words

Acute Pain
Chronic Pain
Pain
Palliative
Assessment
PQRST Scale
Numeric Rating Scale (NRS)
Wong-Baker FACES Pain Scale-Revised (FPS)
Pain Assessment in Advanced Dementia Scale (PAINDS)
Checklist for Non-Verbal Pain Indicators (CNPI)
Modified Comfort Scoring Scale
Premature Infant Pain Profile Pain Assessment Tool (PIPP)
Revised FLACC
Screening

Definitions & Acronyms

Acute Pain	Acute pain is an awareness of noxious signaling from recently damaged tissue, complicated by sensitization in the periphery and within the central nervous system. Its intensity and resolution changes with inflammatory processes, tissue healing and movement. Unpleasant acute pain promotes survival. Acute pain is short-term pain of less than twelve weeks duration.
Pain	Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage (IASP, 2012), Pain can be acute or persistent (chronic) or both at the same time.
Pain characteristics	Pain can be describes according to specific characteristics such as; 1) body area(s) involved; 2) body system(s) affected; 3) duration; 4) frequency; 5) intensity 6) type of sensations (e.g. stabbing, throbbing); and 7) root cause (if known) (Merskey & Bogduk, 1994).
Persistent (Chronic) Pain	Persistent pain is pain that lasts after the usual time for healing (in pain after trauma or surgery) (IASP, 2012b).
Screen	Asking the client for the presence of pain to which a Yes or No answer is required.
Self-report	Ability to communicate either verbally or non-verbally (blinking of eye, writing about one's pain). Self-report requires the capacity to understand the task such as the use of pain scales and the ability to communicate in some manner about the pain experienced. Self-report requires cognitive skills (abstract thinking) and is influenced by context (Zwakhalen et al., 2006).

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Attachment A

Questions to Consider during Assessment of Pain (PQRST)

P – Provoking and precipitating factors, relieving factors

Ask:
- What makes your pain worse?
- What makes your pain better?
- What previous treatment have you tried to relieve your pain?
- Were they effective?

Q – Quality of pain (e.g. burning, stabbing, gnawing, shooting, lancinating)

Ask:
- What does your pain feel like?
- What words would you use to describe your pain?

R – Radiates

Ask:
- Does the pain move anywhere?

S – Severity

Ask:
- Use the Pain Rating Scale to determine the severity of the pain
- How much does it hurt at its worst?
- How much does it hurt at its best?

T – Time

Ask:
- When did your pain start?
- How often does it occur?
- Has its intensity changed?
- How long does it last?