Pain Assessment in Hospice and Palliative Care: Getting Ready for CMS Hospice Item Set

Carol O. Long, PhD, RN, FPCN
Principal, Clinical Educator and Researcher, Capstone Healthcare Adjunct Faculty, Arizona State University College of Nursing

Visiting Nurse Associations of America
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Learning Objectives:

1. Describe the problem of pain in adults and children receiving hospice, palliative care and home care
2. List national mandates related to pain in hospice settings
3. Discuss the completion of the items related to pain in the Hospice Item Set (HIS)
Understanding Pain: An Overview
What is Pain?

• “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” (IASP, 2012)

• “Pain is whatever the person says it is, experienced whenever they say they are experiencing it.” (McCaffery & Pasero, 1999)

• Pain is a silent epidemic! Pain is reported in...
  ▫ 25-50% of older persons living in the community
  ▫ 45-80% in nursing homes
  ▫ 50% of cancer patients at EOL have pain! (ELNEC, 2013)
  ▫ Many older adults who cannot self-report
Multidimensional Model of Pain

Adapted from Loeser JD. In: Bonica’s Management of Pain. Philadelphia; Lippincott Williams & Wilkins: 2001.
Pain and Pain Experiences

- Pain experiences are:
  - Unique and individual for each person
  - Complex in nature
  - Not predictable from person to person

- Pain experiences are influenced by:
  - Physical factors
  - Psychosocial factors
  - Cultural factors
  - Spiritual/existential factors

Thus, multimodal treatment is necessary and self-report is the best indicator of pain...
Nociceptive and Neuropathic Pain
Nociceptive Pain

- **Normal** processing of stimuli
- **Somatic**: Sharp, aching, throbbing
  - Well-localized
- **Visceral**: Intermittent cramping, aching
  - Produced by obstruction of or pressure on hollow organs
  - Pain may be referred to distant sites
  - May be poorly localized
Neuropathic Pain

Abnormal processing of sensory input by central or peripheral neural structures with increased pain threshold & increased sensitivity

• Described as burning, prickling, tingling, stabbing, shooting or radiating

• Pain impulses can be altered in the peripheral nervous system, spinal cord or brain
Nociceptive vs. Neuropathic Pain

Nociceptive Pain
- Postoperative pain
- Mechanical low back pain
- Sports/exercise injuries

Mixed Type
- Arthritis
- Sickle cell crisis
- Postherpetic neuralgia

Neuropathic Pain
- CRPS*
- Trigeminal neuralgia
- Central post-stroke pain
- Neuropathic low back pain
- Distal polyneuropathy (e.g., diabetic, HIV)

*Complex regional pain syndrome.

From: National Initiative for Pain Education, 2005
www.painedu.org
Acute and Chronic, Persistent Pain
# Acute vs. Chronic, Persistent Pain

<table>
<thead>
<tr>
<th>Acute Pain</th>
<th>Chronic, Persistent Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Recent onset</td>
<td>✓ Lasts longer than 3 months in duration or continuous or recurring from chronic condition</td>
</tr>
<tr>
<td>✓ Medical emergency if not expected (e.g., surgery vs. an MI)</td>
<td>✓ Usually lacks objective physical signs</td>
</tr>
<tr>
<td>✓ Short duration</td>
<td>✓ No changes in vital signs</td>
</tr>
<tr>
<td>✓ Usually follows an injury or trauma – the etiology is known</td>
<td>✓ May not ‘appear’ to have pain</td>
</tr>
<tr>
<td>✓ Objective physical signs are present – vital sign changes</td>
<td>✓ Serves no purpose</td>
</tr>
<tr>
<td></td>
<td>✓ Has harmful effects</td>
</tr>
</tbody>
</table>
Conditions for Those in Hospice

- Acute pain alone
  - Post-surgical pain
  - Cancer pain
- Chronic, persistent pain
  - Co-morbidities:
    - Arthritis
    - Low back pain
- Mixed pain: acute and chronic
Other Types of Pain
Referred Pain

- From deep somatic or visceral site to cutaneous region distant but within several spinal segments
- +/- hyperalgesia or allodynia, deep tenderness, muscle spasm
- No muscle atrophy or weakness
- No change in peripheral reflexes
Referred Pain Sites: Examples

Example: shoulder pain - subphrenic abscess
Breakthrough Pain (BTP)

- Transitory episode of moderate to severe pain occurring against a background of persistent pain otherwise controlled by opioid therapy

- Characteristics of BTP
  - Rapid onset
  - Moderate-to-severe intensity
  - Often unpredictable, strikes without warning
  - Relatively short duration
  - On average lasts for up to 30 minutes
  - Possibility of 1-4 episodes per day
  - Types: Incident, idiopathic or end-of-dose failure
At-risk Populations
Children

- At risk for lack of assessment or poor pain management
- Developmental processes and age
- Ability to report pain
- Type of pain
- Numerous types of pain scales; used in different settings
- Pain-related distress or fear
Adults: Factors Affecting the Pain Experience

- Normal aging and comorbidities place the older adult at risk for unrelieved acute pain (MI, fracture, surgery) and adverse events
- Multiple studies report that cognitively impaired patients (e.g., dementia, aphasia) unable to self report pain are at greater risk for untreated pain
- Multiple standardized tools
Adults: Common Conditions Associated with Chronic Pain

- Osteoarthritis (80% are > 65 years)
- Chronic Low Back Pain
- Fibromyalgia
- Neuropathies: peripheral, diabetes, post-herpetic neuralgia (shingles)
- Post-Stroke Syndrome
- Pain treatment is difficult with high incidence of depression and dementia
Hierarchy of Pain Assessment Tools

1. Self report - single most reliable indicator of pain existence and intensity
2. Usual and customary conditions associated with pain
3. Pain behaviors; non-verbal displays
4. Pain assessment by proxy - report from family, friends, caregivers
5. Physiological parameters, if relevant
6. Consider trial of analgesic and observe outcomes (intervention)

Herr, et al., 2011
Summary: Clinical Perspectives

• Pain is an indicator of quality of life
• Less than optimal assessment and management
• Pain is the 5th vital sign
• Clinical quality/process measures:
  ▫ *Palliative and end-of-life care: percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/palliative care initial encounter.*

http://www.qualitymeasures.ahrq.gov/content.aspx?id=36949
### Section J: Health Conditions

#### Pain

**J0900. Pain Screening**

Enter the one-digit code to indicate whether or not the patient was screened for pain. A pain screening includes activities to discern the presence and severity of pain symptoms.

- Enter 0 if a pain screening was not conducted.
- Enter 1 if a pain screening was conducted.

**J0900A. Was the patient screened for pain?**

**J0900B. Date of first screening for pain**

Record the date in MM-DD-YYYY format of the first screening for pain.

**J0900C. Type of standardized pain screening tool used**

Enter the one-digit code to indicate the type of standardized pain screening tool used.

- Code 1 if a numeric scale was used.
- Code 2 if a verbal descriptor scale was used.
- Code 3 if a patient visual scale was used.
- Code 4 if a staff observation tool was used.
- Code 9 if pain was not rated using a standardized tool.

**J0900D. The patient’s pain severity was:**

Enter the one-digit code to indicate the patient’s pain severity score.

- Code 0 if the patient’s pain was none.
- Code 1 if the patient’s pain was mild.
- Code 2 if the patient’s pain was moderate.
- Code 3 if the patient’s pain was severe.
- Code 9 if the pain was not rated.

**J0910. Comprehensive pain assessment**

Enter the one-digit code to indicate whether or not the patient had a comprehensive pain assessment. A comprehensive pain assessment includes activities to gain an understanding of the location, severity, character, duration, frequency, and impact on function and what relieves or worsens pain.

- Enter 0 if a comprehensive pain assessment was not conducted.
- Enter 1 if a comprehensive pain assessment was conducted.

**J0910A. Was a comprehensive pain assessment done?**

**J0910B. Date of comprehensive pain assessment**

Record the date of comprehensive assessment of pain in MM-DD-YYYY format.

<table>
<thead>
<tr>
<th>Item</th>
<th>Definition/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0910C. Comprehensive pain assessment included (Check all that apply)</td>
<td>Record each characteristic included in the comprehensive pain assessment. Check all that apply from:</td>
</tr>
<tr>
<td>1. Location</td>
<td>2. Severity</td>
</tr>
<tr>
<td>3. Character</td>
<td>4. Duration</td>
</tr>
<tr>
<td>5. Frequency</td>
<td>6. What relieves/worsens pain</td>
</tr>
<tr>
<td>7. Effect or function on quality of life</td>
<td>8. None of the above</td>
</tr>
</tbody>
</table>
### BRIEF MEASURE INFORMATION

<table>
<thead>
<tr>
<th>De.1 Measure Title</th>
<th>Hospice and Palliative Care -- Pain Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co.1.1 Measure Steward</td>
<td>University of North Carolina-Chapel Hill</td>
</tr>
<tr>
<td>De.2 Brief Description of Measure</td>
<td>Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.</td>
</tr>
<tr>
<td>2a1.1 Numerator Statement</td>
<td>Patients who are screened for the presence or absence of pain (and if present, rating of its severity) using a standardized quantitative tool during the admission evaluation for hospice / initial encounter for palliative care.</td>
</tr>
<tr>
<td>2a1.4 Denominator Statement</td>
<td>Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days.</td>
</tr>
<tr>
<td>2a1.8 Denominator Exclusions</td>
<td>Patients with length of stay &lt; 7 days in hospice, or &lt; 1 day in palliative care.</td>
</tr>
<tr>
<td>1.1 Measure Type</td>
<td>Process</td>
</tr>
<tr>
<td>2a1.25-26 Data Source</td>
<td>Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record</td>
</tr>
<tr>
<td>2a1.33 Level of Analysis</td>
<td>Clinician : Group/Practice, Facility</td>
</tr>
<tr>
<td>1.2-1.4 Is this measure paired with another measure?</td>
<td>No</td>
</tr>
</tbody>
</table>

De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):
- Part of the PEACE Measures Set
- Paired with Hospice and Palliative Care - Pain Assessment (percentage of hospice or palliative care patients who screen positive for pain and who received a clinical assessment of pain within 24 hours of screening.)
**NQF #1634 Hospice and Palliative Care -- Pain Screening**

**Evaluation Criteria**

1a. High Impact: □ M □ L □ I □

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply): Palliative Care and End of Life Care

De.5 Cross Cutting Areas (Check all the areas that apply): Palliative Care and End of Life Care

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Patient/societal consequences of poor quality, Severity of illness

1a.2 If “Other,” please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):

The Hospice and Palliative Care - Pain Screening measure addresses pain for patients with high severity of illness and risk of death, including seriously and incurably ill patients enrolled in hospice or hospital-based palliative care. Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high rates of pain (40-70% prevalence) and other physical, emotional, and spiritual causes of distress. (1,2) The National Priorities Partnership has identified palliative and end-of-life care as one of its national priorities. A goal of this priority is to ensure that all patients with life-limiting illness have access to effective treatment for symptoms such as pain and shortness of breath. (3) The affected populations are large: in 2009, 1.56 million people with life-limiting illness received hospice care. (4) In 2008, 58.5% of US hospitals with 50 or more beds had some form of palliative care service, and national trends show steady expansion of these services. (5) Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses. (6) The consequences of inadequate screening, assessment and treatment for pain include physical suffering, functional limitation, and development of apathy and depression. (7)

1a.4 Citations for Evidence of High Impact cited in 1a.3:


National Quality Forum #1637

NQF #1637 Hospice and Palliative Care -- Pain Assessment  
NATIONAL QUALITY FORUM  
Measure Submission and Evaluation Worksheet 5.0  

This form contains the information submitted by measure developers/stewards, organized according to NQF’s measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

<table>
<thead>
<tr>
<th>NQF #:</th>
<th>1637</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF Project:</td>
<td>Palliative Care and End-of-Life Care</td>
</tr>
<tr>
<td>(for Endorsement Maintenance Review)</td>
<td></td>
</tr>
<tr>
<td>Original Endorsement Date:</td>
<td>Most Recent Endorsement Date:</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>De.1 Measure Title: Hospice and Palliative Care -- Pain Assessment</td>
</tr>
<tr>
<td>Co.1.1 Measure Steward: University of North Carolina- Chapel Hill</td>
</tr>
<tr>
<td>De.2 Brief Description of Measure: This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.</td>
</tr>
</tbody>
</table>

2a1.1 Numerator Statement: Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain.

2a1.4 Denominator Statement: Patients enrolled in hospice OR receiving palliative care who report pain when pain screening is done on the admission evaluation / initial encounter.

2a1.8 Denominator Exclusions: Patients with length of stay < 1 day in palliative care or < 7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

1.1 Measure Type: Process  
2a1. 25-26 Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record  
2a1.33 Level of Analysis: Clinician : Group/Practice, Facility  

1.2-1.4 Is this measure paired with another measure? No

De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):
Part of the PEACE Measures Set  
Paired with Hospice and Palliative Care – Pain Screening (percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter)

<table>
<thead>
<tr>
<th>STAFF NOTES (issues or questions regarding any criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments on Conditions for Consideration:</td>
</tr>
<tr>
<td>Is the measure untested? Yes ☐ No ☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:</td>
</tr>
</tbody>
</table>

1a. Specific national health go-al/priority identified by DHHS or NPP addressed by the measure (check De.5):  
5. Similar/related endorsed or submitted measures (check 5.1):  
Other Criteria:

Staff Reviewer Name(s):  

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All
### NQF #1637 Hospice and Palliative Care - Pain Assessment

Three subcriteria must be met to pass this criterion. See guidance on evidence.

**Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.**

(evaluation criteria)

1. **High Impact:**
   - The measure directly addresses a specific national health goal/priority identified by DHHS or NQP, or some other high impact aspect of healthcare.

2. **1a. Demonstrated High Impact Aspect of Healthcare:**
   - Affects large numbers, Patient/societal consequences of poor quality, Severity of illness

3. **1a.2 If “Other,” please describe:**

   1a.3 **Summary of Evidence of High Impact (Provide epidemiologic or resource use data):**
   - The Hospice and Palliative Care - Pain Assessment measure addresses pain for patients with high severity of illness and risk of death, including seriously and incurably ill patients enrolled in hospice or hospital-based palliative care. Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high rates of pain (40-70% prevalence) and other physical, emotional, and spiritual causes of distress. 1.2 The National Priorities Partnership has identified palliative and end-of-life care as one of its national priorities. A goal of this priority is to ensure that all patients with life-limiting illness have access to effective treatment for symptoms such as pain and shortness of breath. (3) The affected populations are large; in 2009, 1.5 million people with life-limiting illness received hospice care. (4) In 2008, 69.5% of US hospitals with 50 or more beds had some form of palliative care service, and national trends show steady expansion of these services. (5) Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses. (6) The consequences of inadequate screening, assessment and treatment for pain include physical suffering, functional limitation, and development of apathy and depression.

4. **1a.4 Citations for Evidence of High Impact cited in 1a.3:**
   5. Center to Advance Palliative Care http://www.capcc.org/news-and-events/releases/04-05-10

**1b. Opportunity for Improvement:**

(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b. Briefly explain the benefits (improvements in quality) envisioned by use of this measure:

- Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Poor screening, assessment, and undertreatment of pain is more common for patients with serious illness who are also of minority race/ethnicity. Use of the Pain Screening and Pain Assessment quality measures will increase reporting and efforts to improve awareness of the presence of pain (screening) and assessment of severity, etiology and effect on function (assessment) which are
## Section J: Corresponding HIS Items and Quality Measures

<table>
<thead>
<tr>
<th>Care Process</th>
<th>Relevant HIS Item</th>
<th>Corresponding NQF Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Screening</td>
<td>J0900</td>
<td>NQF #1634 % of patients screened for pain during initial nursing assessment</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>J0910</td>
<td>NQF #1637 % of patients who screened positive for pain who received comprehensive pain assessment within 1 day of screening</td>
</tr>
</tbody>
</table>

NQF #1634 and 1637 are ‘paired’ measures
ELEMENTS in Hospice Item
Set: Pain
J0900. Pain Screening

**J0900A:** Asks... Was the patient screened for pain? (should always be ‘yes’ or ‘1’). If ‘no’ → skip to J2030, Screening for Shortness of Breath

**J0900B:** Date of first screening for pain (if ‘no’ → Skip...)

**J0900C:** The patient’s pain severity was:
- 0. None (if ‘no’ → Skip...)
- 1. Mild
- 2. Moderate
- 3. Severe
- 4. Pain not rated
J0900. Pain Screening (Con’t)

**J0900D**: Type of standardized pain screening tool

- Code 1: Numeric
- Code 2: Verbal Descriptor
- Code 3: Patient Visual
- Code 4: Staff observation
- Code 9: No standardized tool used
Standardized Tool Definition

- Scientifically tested
- Standard response scale
- Appropriately administered
- For the right population
- Under the correct circumstances
- Relevant for the patient’s ability to respond
- Screening is not the same as assessment!
Key Points in Screening

- Evaluate for the presence/absence of pain
- If present, use a standardized tool
- Score greatest severity of pain NOW (at the time of screening)
- Code highest severity
- Code at the time the tool is administered
J0910: Comprehensive Pain Assessment

1. Location
2. Severity (aligns with J0900)
3. Character
4. Duration
5. Frequency
6. What Relieves/Worsens Pain
7. Effect on Function and Quality of Life
9. None of the Above
1. Location

- Use body location chart / schematic
- Probes:
  - Document all locations for all types of pain
  - Note if pain radiates / referred or BTP
  - Look for nonverbal cues for those who cannot self-report
2. Severity

Refers to Intensity and this is completed in the Screening phase (Coded 0-3 or 9)

Use evidence-based assessment tools and ascertain intensity of pain:

- **Self-Report Tools**: ask if the patient has pain! Obtain pain intensity rating.
- **Staff Observation or Behavioral Assessment Tools**: List behaviors that suggest pain. Used for individuals who are unable to self-report. We observe indicators of pain. Total score is derived – cannot be used to calibrate intensity; our best guess.
Severity (con’t)

- Codes: HIS
  - 0: no pain
  - 1: 1-3 is mild pain
  - 2: 4-7 is moderate
  - 3: 8-10 is severe
  - 9: pain not rated

- WHO 3-Step Analgesic Ladder is used based on verbal report and/or intensity of behavioral symptoms

- Pharmacologic interventions: 3 categories
  1. Non-opioids (e.g., acetaminophen, NSAIDS)
  2. Opioids
  3. Adjuvants / Co-analgesics

WHO Pain and Palliative Care Communications Program, 2006
J0900D: Type of Standardized Tools

Self-Report Tools
Code 1. Numeric
Code 2. Verbal Descriptor
Code 3. Patient Visual
Numeric Scales (Code 1)

- 10-point scale
- Symptom Distress Scale (McCorkle)
- Memorial Symptom Scale (MSAS)
- Edmonton Symptom Assessment Scale (ESAS)
1. Numeric Rating Scale (NRS) or 10-point scale

Ask if the person has pain. Then ask ...“On a scale of 0 to 10, with 0 meaning no pain and 10 meaning the worst pain you can imagine, how much pain are you having now?”

Ask them to relay a number or point to the number on the scale.
2. Screening Tool for Neuropathic Pain: ID Pain

**ID Pain: A Neuropathic Pain Screen**

This tool can be used to evaluate presence of neuropathic pain. Ask the older adult the questions below and score as noted. Higher scores are more indicative of pain with a neuropathic component. A score of 3 or higher indicates likely presence of neuropathic pain and justifies a more detailed evaluation. If the older adult has more than one painful area, they are to consider the one area that is most relevant to them.

Conditions that might have a neuropathic pain component include diabetic or peripheral neuropathy, back pain, post-herpetic neuralgia, complex regional pain syndrome, leg/foot pain, large joint pain, and fibromyalgia.

Neuropathic Pain often requires different treatment approaches including use of anticonvulsants, antiepileptics and other adjuvant medications.

Mark “Yes” to the following items that describe your pain over the past week and “No” to the ones that do not.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the pain feel like pins and needles?</td>
<td>Yes: 1  No: 0</td>
</tr>
<tr>
<td>2. Did the pain feel hot/burning?</td>
<td>Yes: 1  No: 0</td>
</tr>
<tr>
<td>3. Did the pain feel numb?</td>
<td>Yes: 1  No: 0</td>
</tr>
<tr>
<td>4. Did the pain feel electrical shocks?</td>
<td>Yes: 1  No: 0</td>
</tr>
<tr>
<td>5. Is the pain made worse with the touch of clothing or bed sheets?</td>
<td>Yes: 1  No: 0</td>
</tr>
<tr>
<td>6. Is the pain limited to your joints?</td>
<td>Yes: 1  No: 0</td>
</tr>
</tbody>
</table>

Verbal Descriptor Scales (Code 2)

- Brief Pain Inventory
- McGill Pain Questionnaire
- 6-point Verbal Pain Scale
1. Brief Pain Inventory

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?
   - Yes
   - No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

   ![Human Figure with Pain Points] (Front and Back Views)

3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.
   - No Pain
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.
   - No Pain
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.
   - No Pain
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.
   - No Pain
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Pain As Bad As You Can Imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%
   - No Relief
   - Complete Relief

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

   A. General Activity
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes

   B. Mood
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes

   C. Walking ability
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes

   D. Normal Work (includes both work outside the home and housework)
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes

   E. Relations with other people
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes

   F. Sleep
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes

   G. Enjoyment of life
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - Does Not Interfere
   - Completely Interferes
2. Verbal Descriptor Scale (VDS) – Pain Thermometer

PAIN THERMOMETER SCALE

- **Pain Thermometer Use:** Good for use with any patient, including those with moderate to severe cognitive impairment or who have difficulty communicating verbally. Have the patient point to the word on the thermometer that best shows how bad or severe their pain is NOW.

- **Pain Thermometer Scoring:** Document the words that the elder points to on this tool. Evaluate the change in pain words selected by the elder over time to determine the effectiveness of pain treatments.

(Herr & Mobily, 1993)
Patient Visual Scales (Code 3)

- FACES Pain Scale-Revised
- Wong-Baker FACES pain scale
- Visual Analog Scale
- Distress Thermometer
1. FACES Pain Scale-Revised (FPS-R)

The FPS-R is a self-report tool that a person may prefer over a NRS; often due to the pictures of 7 faces that range from happy to sad and distressed. Used for adults and children. Revised scale preferred.

• Ask the person if they have pain. Then ask...“The faces show how much pain or discomfort someone is feeling. The face on the left shows no pain. Each face shows more and more pain and the last face shows the worst pain possible. Point to the face that shows how bad your pain is right NOW.”

• Scoring: Score the chosen face as 0, 2, 4, 6, 8 or 10, counting left to right with 0 = “no pain” and 10 = “worst pain possible”

IASP, 2012
2. Wong-Baker FACES Pain Rating Scale


**FIGURE 3.4** Example of how some clinical settings combine the horizontal numerical rating scale (NRS) with word anchors and the Wong-Baker faces scale. These are placed on one card or piece of paper so that the patient has a choice of pain rating scales. If the numerical scale with word descriptors is not easily understood, the faces scale is likely to be. The numbers beneath the faces have been changed from 0 to 5 to a 0 to 10 scale so that the recording of pain intensity is consistently on a 0 to 10 scale.

Faces pain rating scale modified from Wong DL: Whaley & Wong's essentials of pediatric nursing, ed 5, pp. 1215-1216, St. Louis, 1997, Mosby.

**Source:**
3. Visual Analogue Scale
J0900D: Type of Standardized Tools

Code 4: Staff Observation or Behavioral Observation Tools
1. Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)

The PACSLAC is a comprehensive pain assessment tool containing 60 items scored as present or not (use of a checkmark) within the following categories:

1. Facial Expression (13 items)
2. Activity/Body Movement (20 items)
3. Social/Psychiatric/Mood (12 items)
4. Other (Physiological Changes/Eating/Sleeping changes/Vocal Behaviors) (15 items)

NOTE: Useful for comprehensive pain assessment. Newly revised/ copyrighted.

Fuchs-Lacelle & Hadjistavropoulos, 2004
2. Pain Assessment in Advanced Dementia (PAINAD)

*PAINAD can be used by nurse / CNA to screen for pain-related behaviors when observing an activity for 3 – 5 minutes. Score a ‘0’, ‘1’, or ‘2’. Maximum score = 10.*

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breathing</strong></td>
<td>Normal</td>
<td>Occasional labored breathing, short period of hyperventilation</td>
<td>Noisy labored breathing, long period of hyperventilation, Cheyne-stokes respirations</td>
<td></td>
</tr>
<tr>
<td><strong>Independent of Vocalization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative Vocalization</strong></td>
<td>None</td>
<td>Occasional moan or groan, low level of speech with a negative or disapproving quality</td>
<td>Repeated troubled calling out, loud moaning or groaning, crying</td>
<td></td>
</tr>
<tr>
<td><strong>Facial Expression</strong></td>
<td>Smiling or inexpressive</td>
<td>Sad, frightened, frown</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td><strong>Body Language</strong></td>
<td>Relaxed</td>
<td>Tense, distressed pacing, fidgeting</td>
<td>Rigid, fists clenched, knees pulled up, pulling or pushing away, striking out</td>
<td></td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract or reassure</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3. Checklist of Nonverbal Pain Indicators (CNPI)

*Ask if the person has pain... Then observe the person for the following behaviors at rest and during movement. Score a ‘0’ if the behavior was not observed, ‘1’ if occurred briefly during activity or at rest. Total number of indicators is summed with movement, at rest and overall. No cut-off score.*

<table>
<thead>
<tr>
<th>Behavior</th>
<th>With Movement</th>
<th>At Rest</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Vocal complaints:</strong> nonverbal (Sighs, gasps, moans, groans, cries)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. <strong>Facial grimaces/winces</strong> (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. <strong>Bracing</strong> (Clutching or holding onto furniture, equipment, or affected area during movement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. <strong>Restlessness</strong> (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. <strong>Rubbing</strong> (Massaging affected area)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. <strong>Vocal complaints:</strong> verbal (Words expressing discomfort or pain [e.g. ‘ouch’, ‘that hurts’]; cursing during movement; exclamations of protest [e.g. ‘stop’, ‘that’s enough’])</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subtotal Scores</th>
<th>Total Score</th>
</tr>
</thead>
</table>

*Feldt, 2000*
4. Critical Care Observation Tool (CPOT)

*Elements: 4 Behavioral domains and includes patients who are ventilated or not. Facial expressions: 0 (neutral/relaxed), 1 (tender), 2 (grimacing)*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial expression</td>
<td>No muscular tension observed; Presence of frowning, brow lowering, orbit tightening, and levator contraction; All of the above facial movements plus eyelid tightly closed</td>
<td>Relaxed, neutral 0; Tense 1; Grimacing 2</td>
</tr>
<tr>
<td>Body movements</td>
<td>Does not move at all (does not necessarily mean absence of pain); Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements; Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed</td>
<td>Absence of movements 0; Protection 1; Restlessness 2</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>No resistance to passive movements; Resistance to passive movements; Strong resistance to passive movements, inability to complete them</td>
<td>Relaxed 0; Tense, rigid 1; Very tense or rigid 2</td>
</tr>
<tr>
<td>Evaluation by passive flexion and extension of upper extremities</td>
<td>Alarms not activated. Easy ventilation; Alarms stop spontaneously; Asynchrony: blocking ventilation, alarms frequently activated</td>
<td>Tolerating ventilator or movement 0; Coughing but tolerating 1; Fighting ventilator 2</td>
</tr>
<tr>
<td>Compliance with the ventilator (intubated patients)</td>
<td>Talking in normal tone or no sound; Sighing, moaning; Crying out, sobbing</td>
<td>Talking in normal tone or no sound 0; Sighing, moaning 1; Crying out, sobbing 2</td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocalization (extubated patients)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Figure 3. The Critical Care Pain Observation Tool can assess nonverbal patient indicators of pain in four areas: facial expression, body movements, muscle tension, and ventilator compliance (Gelinas et al., 2008).*
5. **Face, Legs, Activity, Cry, Consolability (FLACC)**

*FLACC can be used by nurse / CNA to screen for pain-related behaviors when observing an activity for 3 – 5 minutes. Score a ‘0’, ‘1’, or ‘2’. Maximum score = 10. Best use is in young children.*

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

*Note: Each of the five categories Face (F), Legs (L), Activity (A), Cry (C), and Consolability (C) is scored from 0-2, which results in a total score between 0 and 10.*

3. Character

- Ask: Tell me about the character of your pain?
- Words to describe pain:
  - e.g., aching, sharp, dull, squeezing, radiating, tender, throbbing, burning, tingling, etc.
- Probes:
  - Type (one or both)
    - Acute
    - Chronic, persistent
  - Character (one or both)
    - Nociceptive
    - Neuropathic
- Medical record captures the descriptors
4. Duration

- Ask: How long has the pain you describe been a problem?
- Probes:
  - Examine medical history
  - Gather analgesic history
  - Differentiate type and character of pain (e.g., acute, chronic, referred, radiating, nociceptive/neuropathic, breakthrough)
  - Be sensitive to the person who cannot self-report; note duration of behaviors that suggest pain
5. Frequency

- Ask: How often does the pain occur? Be aware of nonverbal patient.
- Think about pattern:
  - Intermittent vs. constant vs. mixed
- Probes:
  - Use a day cycle or pain diary
  - Explore radiating or BTP
  - Always think of interventions that will address pain cycles
6. What Relieves/Worsens Pain

- **Ask:**
  - What makes the pain better?
  - What makes the pain worse?

- **Probes:**
  - Basic needs, nonpharmacologic, pharmacologic
  - Physical, psychological, emotional, spiritual or even total pain at end-of-life
  - Example: note if actions increase/decrease pain for nonverbal patients
7. Effect on Function and Quality of Life

- Ask: How does pain affect your ability to function and do what you like? And quality of life.
- Probes:
  - Any change in your activity level?
  - What can you *not* do due to pain?
  - What *could* you do if pain was controlled?
- Note:
  - Be sensitive to non-verbal cues; explore and validate
  - Examine patient’s goals of care
9. None of the above

If there is no documentation that any of the above characteristics (1-7) were included in the pain assessment
HIS is not a comprehensive pain assessment tool!

- Only minimum data
- These are process measures, not outcomes
- Other pain assessment measures need to be collected:
  - Onset
  - Psychosocial and spiritual assessment
  - Beliefs and attitudes
  - History of analgesics and treatments
  - Associated symptoms, e.g., depression
  - Self-identified goal for pain relief and quality of life factors
  - And more....
When to Conduct Pain Assessment

- On admission; screen
- When you suspect new pain: on movement or at rest
- Exacerbations, uncontrolled pain
- New therapy (e.g., new meds, rotation of meds, etc.)
- Around the clock; especially if the person is receiving active pain treatment
- At each interdisciplinary team meeting (Pain is the 5th Vital Sign)
- Whenever you are evaluating the outcomes of your intervention!
Summary

THANK-YOU!

Questions?

Carol O. Long, PhD, RN, FPCN
carollongphd@gmail.com
Visit me on:
LinkedIn