Clinical Conditions and Symptom Management: Pain Assessment and Management

VNAA Best Practice for Hospice and Palliative Care
Experts stress that “Pain is what the patient says it is” and should be treated accordingly (Herr, 2006, Pasero, 2011). Pain is an internal, subjective experience that cannot be directly observed by others or by the use of physiological markers or lab tests. The American Society for Pain Management reported 51% of patients overall had pain at the end of life. A core tenant of hospice care is to adequately manage pain according to the patient and caregiver preferences.
Why Pain

• Pain is a prevalent and an under treated symptom.
• Pain management is a high priority for patients and caregivers.
• Pain screening and assessment are critical steps in pain management and treatment.
• Pain screening and assessment are required on the Hospice Item Set.
Definition of Best Practices

1. All patients are **screened** during the initial RN assessment for the presence or absence of pain and its **severity**, if present, using an appropriate, standardized tool (Pain Screening HIS J0900A). If pain is present, a comprehensive pain **assessment** appropriately administered and relevant for the patient’s ability to respond is completed within one day of screening (Pain Assessment HIS J0910).

2. Ensure that patient’s pain is at an acceptable level for the patient before ending hospice visit and re-evaluate within 24 hours.

3. Patients treated with an opioid are prescribed a bowel regimen within 1 day of opioid prescription, or have documentation why it is not needed (HIS Initiation/continuation of Bowel Regimen)
Critical Interventions/Actions

• Determine which tools to use based on whether patient is cognitively intact and can self-report or not.
• Use a brief tool for reassessments.
• Evaluate changes in pain status at each visit.
• See Recommended TOOLS for pain screening below.
Critical Interventions/Actions - 2

• For screening VNAA recommends initial screening with a standard Verbal Descriptor Scale (VDS) such as the Iowa Pain Thermometer. The Faces Pain Scale R or FPS-R tool is also recommended.

• The VNAA’s recommends the FLACC for child assessment and the PAINAD tool for screening of persons unable to self-report.

• Pain assessment tools may not directly correspond to CMS-coding categories of mild/moderate/severe. Develop crosswalks to CMS coding for screening and assessment tools.
Critical Interventions/Actions - 3

- A comprehensive pain assessment should include the following domains: location, severity, character, duration, frequency, what relieves/worsens pain, effect on function or quality of life.
- See Clinical practice guidelines (ICSI, 2013; Horgas, 2013) for suggested additional items that a comprehensive assessment of pain could include.
Critical Interventions/Actions – 4

• The Pain Plan should include both non-pharmacologic and pharmacologic interventions.

• Detailed intervention strategies can be found in several tools including the VNAA Clinical Procedure Manual, the SCCPI Cancer Pain Management Reference Card, and the Principles of Pain Management Adult Guide. (link to these resources and others as recommended).

• Teach the patient and caregiver how to use pain medications (See VNAA Module Medication Reconciliation and Management).
Critical Interventions/Actions – 5

- Staff should be trained to consider whether cultural influences, spiritual/existential, or psychosocial concerns are impacting the patient and caregiver experience of pain.
- Patient pain status should be reviewed at each IDT.
- Explicitly document the patient’s goals for managing pain.
- The hospice assures immediate access to medications needed for prompt relief of symptoms that commonly arise in terminally ill patients.
Standardized Tools

- **The Faces Pain Scale-Revised or FPS-R** (patient visual) are recommended as two of the most validated and commonly used tools to assess for presence and intensity of pain (Hicks, 2001, Bieri, 1990).
- **Numeric Rating Scale** (verbal descriptor) Rates pain on a scale of 0-10.
- **10 Point Scale** - The 10 point scale is a vertical or horizontal line numbered 0-10. 0 is labeled “no pain”, and 10 is labeled “worst possible pain.” The patient is asked to point or verbalize the number that best reflects the current level of pain. It can be used to evaluate changes in pain over time.
- **Wong-Baker FACES Pain Scale** (patient visual) used for children. Aligns the numeric rating scale with the appropriate sad/neutral/happy face.
- **Brief Pain Inventory (BPI)** (verbal descriptor) captures additional information on pain characteristics.
- **FLACC** - for assessment for young children (patient visual) Evaluates indicators of a baby’s pain; face, legs, activity, cry and ability to console child.
- **McGill Pain Inventory Short Form** (verbal descriptor) Like type scale used to help patients report the quality and characteristics of their pain.
Standardized Tools - 2

- **Pain assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)** (staff observation) rates Facial Expression; Activity/body movement; Social/personality/mood and other physiological changes as evidence of pain in adults unable to verbalize pain.
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- **Pain assessment in Advanced Dementia (PAIN-AD)** (staff observation) rates Breathing Independent of Vocalization; Negative Vocalization; Facial Expression; Body Language; and Consolability to assess for pain in patients unable to self-report pain.

- **Pain Thermometer** - Visual tool enables the patient to point to a level of pain that corresponds to temperatures on a vertical thermometer.
Standardized Tools - 3

- **Symptom Distress Scale** - This multi-symptom assessment tool asks patients to rate their symptoms on a scale of 1-5 based on descriptive information that accompanies each number. Symptoms include nausea, appetite, insomnia, pain, fatigue, bowel problems, and concentration. Rating of 1 is no problem, and 5 is maximal problem resulting from the symptom.

- **CNA Pain Assessment Tool (CPAT)** - Nursing home assessment for patients with dementia

- **Elderly Pain Caring Assessment 2 (EPCA-2)** - Observational assessment for non-verbal elders

- **Memorial Symptom Assessment Scale (MSAS)** - This tool evaluates for the presence of multiple physical and psychological symptoms including pain and shortness of breath, and asks the patient to rate frequency, severity, and how much the symptoms “distress or bother” them on a scale of 0-4. The tool has been validated against other tools and in a variety of populations. A short form is available.
Standardized Tools - 4

- **Non-Communicative Patient’s Pain Assessment Instrument (NOPPAIN)** - Observational assessment for non-verbal elders
- **Discomfort Behavior Scale** - Observational assessment for non-verbal elders
- **Principles of Pain Management Adult Guide** (Patricia A. Bomba, MD, FACP)
- **Visual Analog Scale**
- **Verbal Pain Intensity Scale**
Measurement and Evaluation

1. Percentage of patients who have been screened for pain during the initial nursing assessment - HIS PAIN SCREENING measure J0900.
2. Percentage of patients who screened positive for pain who received a comprehensive pain assessment within 1 day of screening – HIS PAIN ASSESSMENT measure J0910.
3. Percentage of patients treated with an opioid who are prescribed a bowel regimen within 1 day of opioid prescription, or who have documentation why a bowel regimen is not needed –HIS Initiation/continuation of Bowel Regimen measure N0520.
4. Percentage of patients experiencing pain who report acceptable level comfort by the end of the hospice visit.