

Key for Use of The Pain Assessment Tool

Location of Pain:

Indicate on the part of the body where the person reports feeling pain. If the pain starts at a certain point then travels, you can indicate the direction and extent of the travel with an arrow.

If the person indicates more than one type or location of pain, use a separate assessment form for each different location as appropriate.

Intensity:

The person will be requested to answer the questions in the table as they relate to each identified pain. The preferred pain tool is 0-10. If the person is finding this confusing or is unable to comply, then use the facial grimace scale as an objective measure.

Quality:

Go over each pain location to identify the appropriate descriptors from the list or if the person has a different descriptive word, record this beside "other".

If the person has difficulty using word descriptors, you may prompt him/her with the word list provided.

Effects of pain on activities of daily living (ADL's):

You want to find out if any of the pains identified in the "location of pain" and "intensity" section are affecting any of the activities of daily living listed. Tick "yes" or "no".

If pain is causing a problem in any of the ADL's, indicate in the comments column which pain is causing the problem and in what way.

It is also important to know if the person feels that help is needed with any of the activities identified as a problem or if they are content to live with it. If the person wants help, this would then suggest a need to refer to the appropriate care provider.

The following are some additional questions and/or points that you may find helpful when asking about the specific ADL areas. Also, included are possible *referrals to the professional(s), who are experts in the different areas.

1. Sleep and Rest:

Ask - How often do you wake in the night? How many nights of the week? What is a good or bad night? What position do you sleep in? Do you use any special positioning devices? What do you do when the pain wakes you?

*OT/PT/RN/DR/PC/SW

2. Social activities:

Includes leisure (hobbies), recreational activities, shopping, visiting family/ friends.

*OT/SW/Volunteers.

3. Appetite:

Number and size of meals taken.

Is it pain induced nausea? Did the nausea start when you started on the pain medication?

4. *Dietitian/ RN Physical activity and mobility:

Moving in bed; transfers to bed, chair, toilet; stairs; walking; other exercise; sports; personal care; bathing, dressing, grooming, eating; medication management.

*OT/RN

5. Emotions:

Any change, as a result of the pain, and if so, is this significantly interfering with activities so that intervention would be helpful.

*SW/PC/Volunteer

6. Sexuality and intimacy:

Is the pain resulting in a significant reduction in desire for sexuality/intimacy or making the physical movement required too painful? In both cases, is this a concern for the person?

*SW/PT/OT/RN/DR

Effects of pain on your quality of life:

What would you like to do that you can't because of the pain? Often this question is answered with very simple statements such as, "I would like to cook a meal" or, "I would like to sit with my family for a meal". Answers to this question help to establish a pain management goal.

This can be a very difficult subject to try to describe, which is why some descriptors have been included to assist the person: happiness, contentment and fulfillment. Have the person indicate which activity can no longer be done that is important to him/her. Ask how we can help.

Symptoms:

Have the person identify from the listed symptoms which ones are affecting his/her quality of life. Check appropriate ones.

Behaviours:

Have the person identify disturbing behaviours if possible and/or the assessor will identify and check exhibited behaviour(s).

Past pains:

It is important to delve into the person response to past treatment. Have the person describe the pain incident and his/her coping methods.

Support System:

Who is available for support in the event of a pain or symptom crisis? This can be any person who is involved in the person's life and is recognized by the person as a "significant other".

Other Concerns Related to Pain:

This is an opportunity to discuss any concerns that the person/family may have about pain management, especially issues that they may have with the use of opioids.

Nursing Pain Diagnosis: Based on the person's report of location, severity and quality of pain, you will have the necessary information to make a nursing pain diagnosis.

There are four classifications of pain; nociceptive pain, neuropathic pain, mixed pain and pain of unknown origin.

1. Nociceptive:

Nociceptive pain is caused by direct stimulation of peripheral nociceptors. It is usually associated with tissue damage as well as inflammatory processes. Nociceptive pain is subcategorized into visceral and somatic pain.

Visceral:

Constant, dull, aching, poorly localized pain that has a gradual onset often felt at a distance from the origin (referred pain), e.g., pelvic visceral pain is often referred to the sacral or perineal area.

- a) Solid Viscera (ex: liver, pancreas)
 - if intense, can be sharp and penetrating
- b) Hollow Viscera (ex: bowel, bladder)
 - diffuse, or colicky pain
 - feeling of pressure or fullness caused by blockage of previously open “tunnel”
 - may have shortness of breath or cough with thoracic viscera
 - abdominal distention, nausea, vomiting with abdominal viscera

Somatic:

Constant gnawing or aching, usually well localized, worse on movement or weight-bearing if in pelvis, hips, femur, joints or spine. Deep somatic pain involves stimulation of nociceptors found in muscle, bone, joints and ligaments. Examples of this are:

- bony metastases
- skin invasion or ulceration – this is known as “superficial somatic pain”
- muscle invasion, soft tissue masses
- pathologic fractures
- osteo-arthritis and other bone destructive diseases
- may be present in back and shoulder if it involves T1

****Note- Incident Pain is a type of breakthrough pain that is made worse by movement, such as pain on weight bearing in severe osteoarthritis or bone metastases.***

2. Neuropathic:

Neuropathic pain is caused by pressure, invasion or destruction of peripheral or central nervous tissues, which leads to complex and abnormal spinal cord or thalamic neural processes that produce sustained pain.

- A burning, deeply aching quality that may be accompanied by some sudden, sharp lancinating pain
- Often a dermatomal or peripheral nerve distribution or radiation
- Numbness or tingling over the area
- Hyperalgesia over an area of skin – an increased painful response to a mildly painful stimulus (e.g., pinch, prick)
- Severe pain from even slight pressure from clothing or light touch (allodynia)
- Usually constant and severe pain often precedes sensory and motor loss (e.g., spinal cord compression)
- Often strange word descriptors will indicate neuropathic pain, e.g., “my feet feel wet all the time”

3. Mixed:

Mixed pain in many instances is a combination of nociceptive and neuropathic pain.

- tumour invasion of pancreas with spread to and destruction of vertebra including spinal cord compression.

4. Unknown:

Persistent pain, the cause of which cannot be determined by history and investigations.

- may be described with all the current word descriptors
- patient is often not believed if investigations are inconclusive
- is usually under treated
- can be debilitating
- lifelong suffering may lead to depression

Problem List:

Using the "Pain Assessment Tool" "tick" the nursing pain diagnosis(es) and list them on the care plan or document as per agency policy. If you identify a problem that the person did not, it is important to ensure the resident agrees and understands why this is a problem.

Goals and Plans:

From the problem list, the person creates goals and you work together to identify the interventions. Use of the Pain Flow Record is essential for follow-up and evaluation.