Taking the Pain out of Pain Management: *One Step at a Time*

Assessment of Pain

Host and Moderator: Amanda Tevelde

Presenters: Julie Leighton-Phelps RN, BScN, CHPNC

Inge de Bruijn, RN CHPNC(C)

Date: June 29th, 2023

Project ECHO Palliative Care - Canada BY Pallium Canada

NSMHPCN North Simcoe Muskoka Hospice Palliative Care Network

Land Acknowledgement

We would like to acknowledge that the land which we are gathered on today is the traditional territory of the Anishinaabek Nation; specifically, the Chippewa Tri – Council comprised of the Chippewas of Beausoleil, Rama and Georgina Island First Nations and more recently the Mississaugas of the Credit River First Nation.

Ontario is covered by 46 treaties and other agreements and is home to many Indigenous Nations from across Turtle Island, including the Inuit and the Métis. These treaties and other agreements, including the One Dish with One Spoon Wampum Belt Covenant, are agreements to peaceably share and care for the land and its resources. Other Indigenous Nations, Europeans, and newcomers were invited into this covenant in the spirit of respect, peace, and friendship.

Most of us have come here as settlers, immigrants, or newcomers in this generation or generations past.

We are all Treaty people. Every day we are mindful of broken covenants, and we strive to make this right. We commit to collaborating based on the foundational assumption that Indigenous Peoples have the power, strength, and competency to develop culturally specific strategies for their communities. We are dedicated to honouring Indigenous self-determination, history, and culture, and are committed to moving forward in the spirit of reconciliation and respect with all First Nation, Métis and Inuit people.

The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

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Thank You

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Health Canada Santé Canada

Introductions

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Thank you for joining us today!

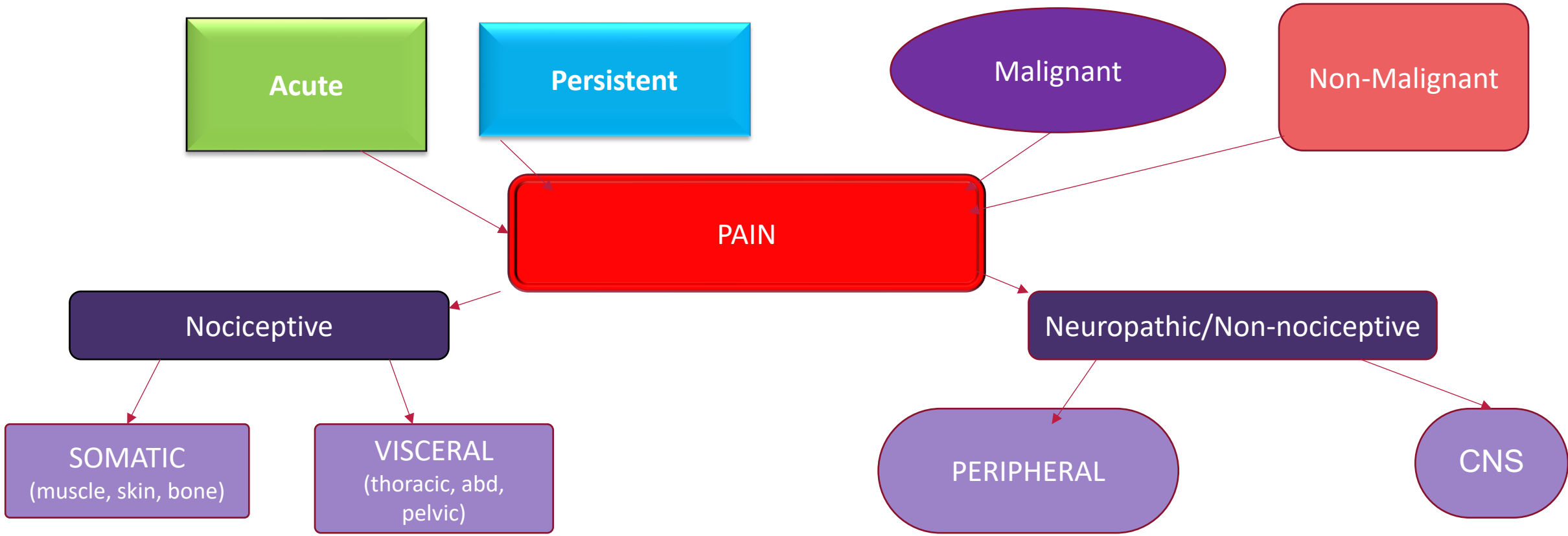
Please remember to complete the satisfaction survey following todays session.

Learning Objectives

By the end of the session, participants will be able to:

- Understanding the Importance of Pain
- Understanding the difference between Screening vs Assessment
- Outline and Identify Gold Standard Assessment Tools for Pain
- Identify Pain Assessment Tools in Cognitively Intact Individuals and Cognitively Impaired Individuals

Classification of Pain



Pain Assessment

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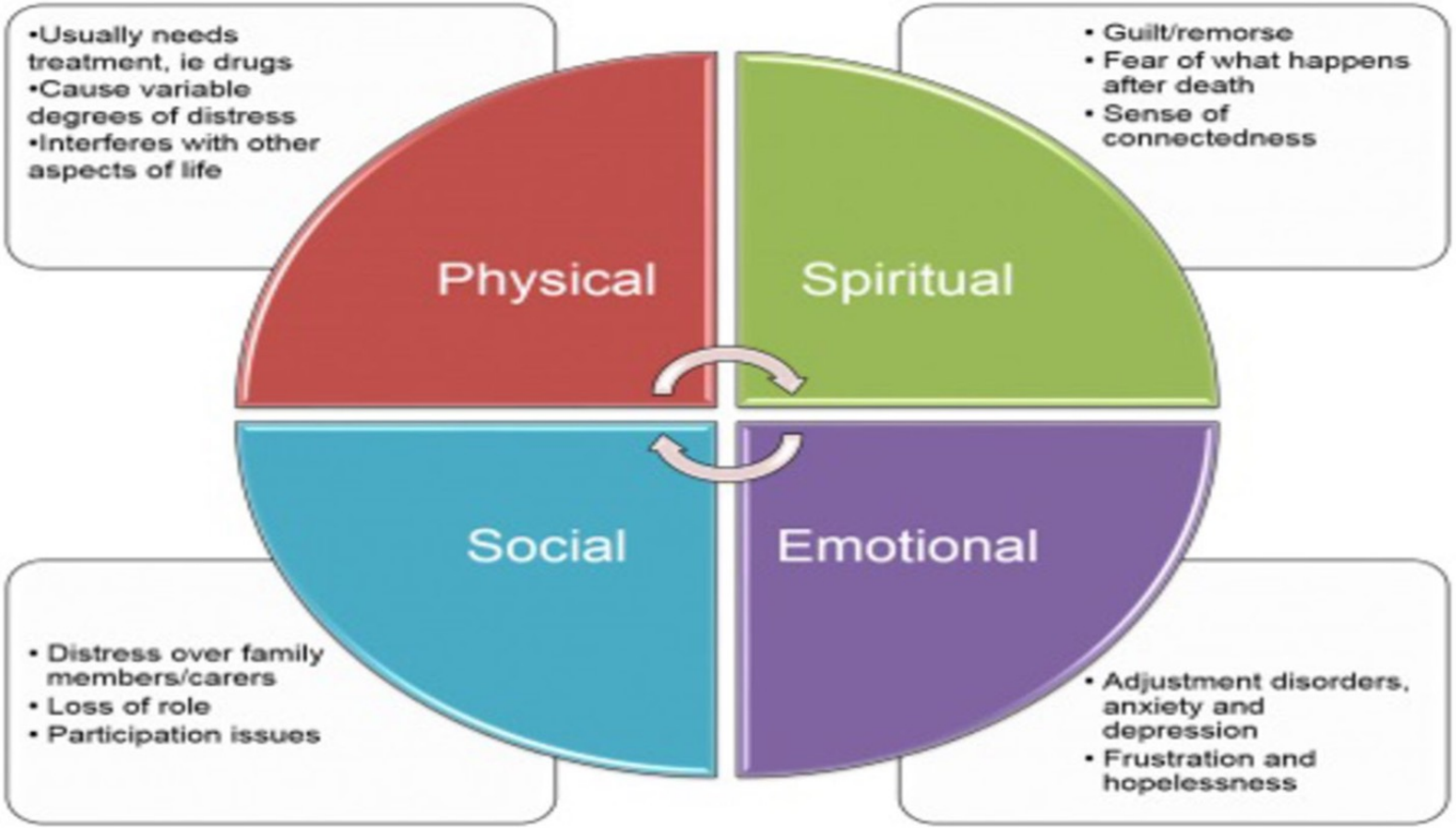
Importance of Pain Assessments

- Assessments should strive to identify the pathophysiological mechanisms underlying the pain
- Pain serves as an indicator on the severity of the condition and helps to guide treatment
- A communication tool for patients to express their pain
- Pain is often undermanaged/undertreated
- Effective pain management is reliant on proper assessment

Barriers to Pain Assessment

- Cognitive impairment, unable to focus, depressive moods
- Inaccuracy of patients pain memory
- Language barriers, learning difficulties
- Intubated and/or sedated patients
- Lack of knowledge, experience and/or awareness of the assessing clinician
- Crisis situations
- Pediatrics
- Fears: of being a burden or bothering staff or of addiction or overdose which may report an under-rating of the severity of pain (may affect pain treatment plan)

Assessment of Total Pain



(Harrop et al., 2017)

Screening vs. Assessment

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Screening vs. Assessment

- Screening can be something as simple as “are you having pain”
- It identifies immediate and current health needs
- And determines the need for further evaluation and treatment/support

Assessment is a comprehensive system of gathering key information, it enables clinicians to identify health concerns or diagnoses.

It usually considers multiple domains and identifies both strengths and barriers that may impact treatment

Components of a Pain Assessment

1. Gather information from the person, family, and interdisciplinary team using an assessment tool (alphabet tool)
2. Pain history
3. Physical examination
4. Consider other sources of information such as imaging, lab tests, other diagnostic tests
5. Know current medication regime (especially dose and timing) and the number of PRN doses being used

Descriptor Words for Pain

- Burning
- Stabbing
- Pressure
- Sharp
- Referred Pain
- Deep
- Throbbing
- Tingling
- Pins and Needles
- Spontaneous
- Severe
- Electrical
- Squeezing
- Numbness
- Gnawing
- Cramping
- Poorly or Well Localized
- Very Distressing
- Stabbing
- Aching
- Shooting
- Increasing with touch, movement or weight bearing

*may be associated with nausea, vomiting, diaphoresis

Cancer Care Ontario Pain Algorithm

Screening with ESASr and Performing Clinical Assessment

1. ESASr

ESASr is a valid and reliable symptom screening tool which can be used to identify a patient's pain level on a scale from 0-10. In many patients the ESASr pain scores may suggest the following: 1-3 = Mild Pain, 4-6 = Moderate Pain, and 7-10 = Severe Pain. ESASr scores should not be considered in isolation.

Whenever pain is endorsed at any level, further assessment is required to understand the ESASr scores meaning and impact. The following **Pain Assessment Acronym** should be used to help determine the best pain management approach.

2. Adapted Pain Assessment Acronym: OPQRSTUV (adapted from Fraser Health[1])

Onset	When did it begin? Is it new? How long does it last? How often does it occur?
Provoking/ Palliating	What/ who brings it on? What/who makes it better? What/ who makes it worse?
Quality	What does it feel like? Can you describe? Examples provided below: **Nociceptive** • Sharp, aching, throbbing **Neuropathic** • Shooting, burning, tingling, painfully numb • Allodynia/hyperalgesia
Region/ Radiation	Where is it? Does it spread anywhere?
Severity	What is the intensity of this symptom? Right now? At best? At worst? On average?
Treatment	What medications or treatments are you currently using? What medications have you tried in the past for this, and how well did they work? Do you/did you have any side effects from the medications/treatments?
Understanding/ Impact on you	What do you believe is causing this symptom? How is this symptom affecting you/your level of functioning and/ or your family?
Values	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom? Are there any other views or feelings about this symptom that are important to you and your family?

3. Additional Areas for Assessment

Physical assessment (focus on the area of pain to determine cause of pain)
- Site and number of pains, intensity and severity of pains, timing of pains, etc.[2]

Pertinent history (risk factors)
- Analgesic drug history,[2] multiple cancer mechanisms,[3] premorbid psychiatric conditions[4] etc.

Psychosocial and spiritual assessment
- Assess for psychosocial or spiritual distress, coping deficits, i.e. psychogenic effects.

Risks for addictions
- History of alcohol or drug abuse, family history of alcohol or drug misuse, etc.[5]

Please see page 4.

Mild Pain
- Generally tolerated by the patient and does not interfere with quality of life
- Patient can be easily distracted from the pain
- Generally does not interfere with activities of daily living (ADLs)

Moderate Pain
- Patient states they cannot manage pain
- Pain is interfering with quality of life
- Patient feels it is difficult to concentrate because of pain
- Hard to distract from the pain
- Pain is interfering with function and ADL's

Severe Pain
- Patient is in acute distress or discomfort
- Patient is completely focused on pain
- Patient is unable to complete activities
- Pain dominates quality of life
- Pain onset is sudden and acute
- Acute exacerbation of previous levels
- Pain may present at a new/ different site

(CCO, 2022)

Cancer Care Ontario Pain Algorithm

Pain Map: Pain in Cancer Patients

Mild Pain

Treatment with Non-Opioids

- Acetaminophen, adjuvant analgesics and NSAIDS should be considered at the lowest effective dose.
- The need for ongoing or long term treatment should be reviewed periodically; if there is no significant response in one week drugs should be stopped.
- Meperidine and pentazocine should not be used.
- Long term use of NSAIDs requires gastric mucosa protection.
- There is insufficient evidence to recommend bisphosphonates for bone pain management.

Moderate Pain

Treatment for Opioid Naïve Patients

- Morphine starting dose is usually 5mg PO 4h with 2.5-5mg PO q1h prn for breakthrough pain. For elderly or frail patients, consider a starting dose of 2.5mg PO q4h.
- Hydromorphone starting dose is 1mg PO q4h with 0.5 to 1mg PO q1h prn for breakthrough pain. For elderly or frail patients consider a starting dose of 0.5 mg PO q4h.
- Oxycodone starting dose is 2.5 mg or one half tablet PO q4h, with 2.5 mg or one half tablet PO q4h prn for breakthrough. The lowest dose oxycodone tablets available, either in combination with acetaminophen or alone, contain 5mg of oxycodone. This is equivalent to approximately 5 to 10mg of oral morphine.

Severe Pain

Treatment for Opioid Naïve Patients

- Oral: Morphine 5 to 10 mg PO q4h and 5mg PO q1h prn or hydromorphone 1 to 2 mg PO q4h and 1 mg PO q1 to q2h prn.
- Subcutaneous/Intravenous: Morphine 2.5 to 5 mg SC/IV q4h & 2.5 mg q30min SC/IV prn or hydromorphone 0.5 to 1 mg SC/IV q4h & 0.5 mg SC/IV q30min prn.

Pain Crisis

Pain Crisis can occur at any time.

- A severe pain crisis requires prompt use of analgesics, adjuvant therapies, reassurance and a calm atmosphere.
- Consider a consultation to palliative care or cancer pain specialist
- If IV access is present, and the person is opioid naïve, give stat morphine 5 to 10 mg IV q10min until pain is relieved;
- If IV access is present and the patient is taking oral opioids, convert the PO dose to IV, and administer IV q15min until pain is relieved. Monitor carefully.
- If IV access is not present and the patient is opioid naïve, give stat morphine 5-10 mg subcutaneous q30min until pain is relieved.
- If IV access is not present, and the patient is opioid tolerant, convert the PO dose to subcutaneous, and administer q15min until pain is relieved. Monitor carefully.
- Titrate dose by 25% every 1 - 2 doses until pain is relieved.
- Do not try to manage a severe pain crisis with a long-acting opioid.

Treatment with Opioids (opioid naïve or opioid tolerant)

- For mild to moderate pain, a weak or lower potency opioid could be given in combination with a non-opioid analgesic.
- If pain is not controlled with these combinations, go to "Moderate Pain - Treatment with Opioids."

Treatment with Opioids

If the patient is taking an opioid…

- Oral administration should be used over other routes.
- As an immediate release preparation with q4h dosing, increase the regular and breakthrough doses by 25% from the starting dose, q24-q48hs, if pain uncontrolled. Monitor side effects.
- As a sustained release opioid, increase this dose by 25%. Change the breakthrough dose to 10% of the total 24h dose, either q1 to 2h prn PO or q30 min prn subcutaneous.
- Make frequent assessments and adjustments to the opioid dose until the pain is better controlled.
- Once patients have achieved stable pain and analgesic usage on oral morphine, oxycodone or hydromorphone, they should have their medication converted to a sustained or controlled release formulation given q12h for ease of administration. The short acting breakthrough dose is usually 10% of the total daily dose given at a frequency of q1 to 2h prn
- If pain is not well controlled despite multiple breakthrough doses, consider poor absorption, opioid induced hyperalgesia, or the need for adjuvants or non-pharmacologic interventions.

Treatment with Opioids

- If the patient is taking an opioid with q4h dosing, increase the regular and breakthrough doses by 25%. Ensure that the breakthrough doses are 10-15% of the daily dose. Ensure that the frequency of the breakthroughs are q1h prn if PO and q30min prn if subcutaneous.
- If the patient is taking a sustained release opioid, increase this dose by 25%, and change the breakthrough doses accordingly.
- Adjust the regular and breakthrough opioid dose every 24h to 48h to reflect the previous 24h total dose received.
- If unmanageable opioid-limiting adverse effects are present (e.g. nausea, drowsiness, myoclonus), consult a palliative care service to assist with rotating to another opioid.
- If there is difficulty getting the pain under control consider a consultation to palliative care.

Follow-up and ongoing monitoring should take place at all pain levels

If pain remains unrelieved despite the approaches outlined above, request the assistance of a palliative care consultation team.

Assessment Tools for Pain

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Choosing and Utilizing Pain Assessment Tools

- Validated
- Reliable
- Easy to use

*** Tools should not replace a thorough clinical assessment*

Pain Assessment Tools: Cognitively Intact

- Edmonton Symptom Assessment Scale (ESAS)
- Use of descriptor words
- Wong Baker Faces
- McGill Pain Questionnaire
- OPQRSTUV

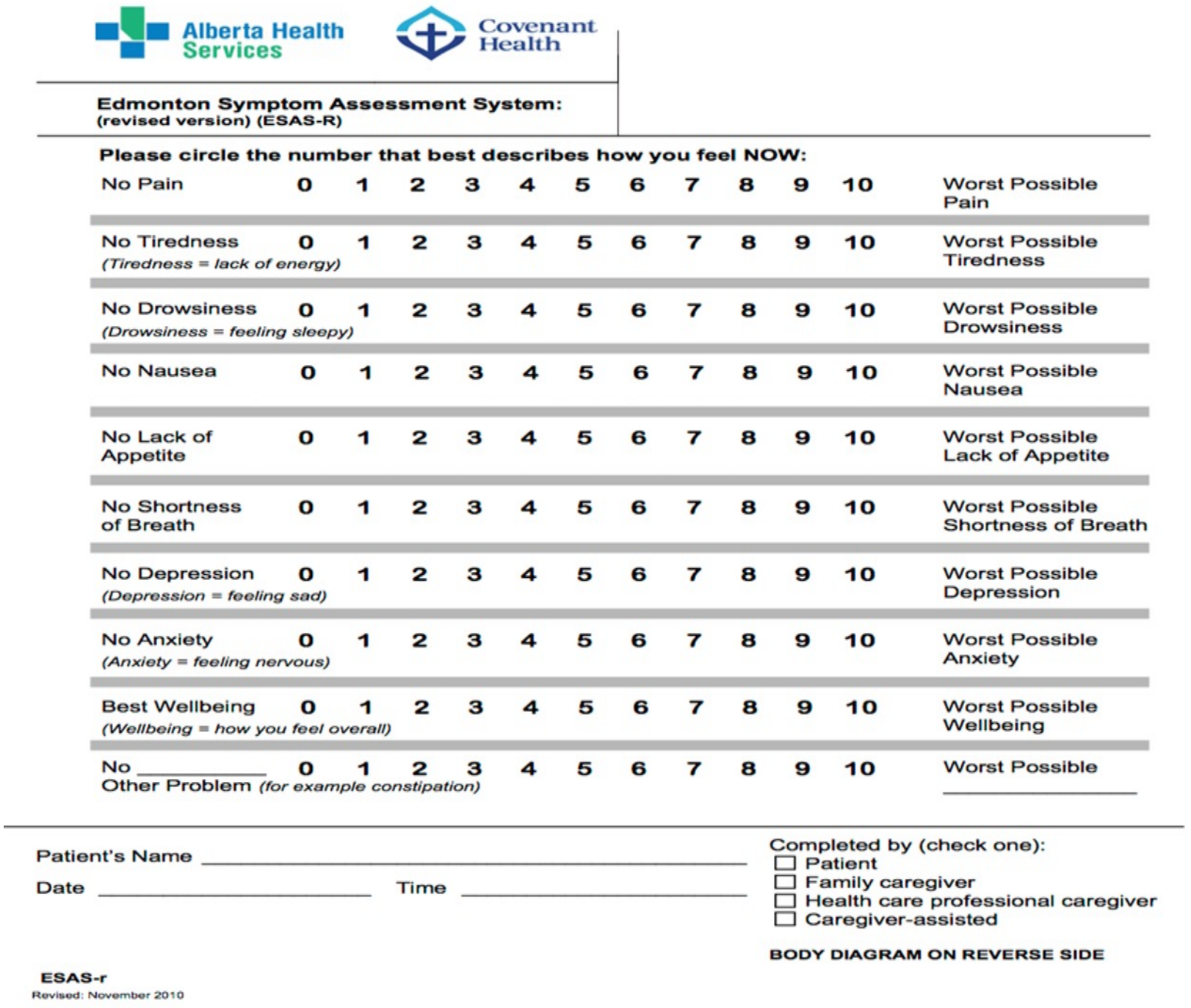
*** Not an exhaustive list*

Edmonton Symptom Assessment System (ESAS)

- Numerical scale that not only assesses pain but many other associated symptoms (i.e. anxiety, depression, nausea, etc.)
- Can be used as a trending tool to monitor pain levels over time
- Should be utilized before and after any intervention (medication or positioning, use of heat/ice, etc.)
- Should only be completed by the person themselves and not by the clinician or family

(Cervantez, 2018)

Edmonton Symptom Assessment System (ESAS)



Alberta Health Services

Covenant Health

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name _____

Date _____ Time _____

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: November 2010

OPQURSTUV

O- onset

P- provokes +palliates

Q- quality of pain

R- region + radiation

S- severity/intensity

T- treatment + timing

U- understanding, how does the pain affect YOU?

V- values/goals related to you and your family

(Frazer Health, 2012)

O - Onset

- When did it begin?
- Is it new?
- How long does it last?
- How often does it occur?

P - Provoke/Palliate

- What brings it on
- who brings it on?
- What makes it better?
- What makes it worse?

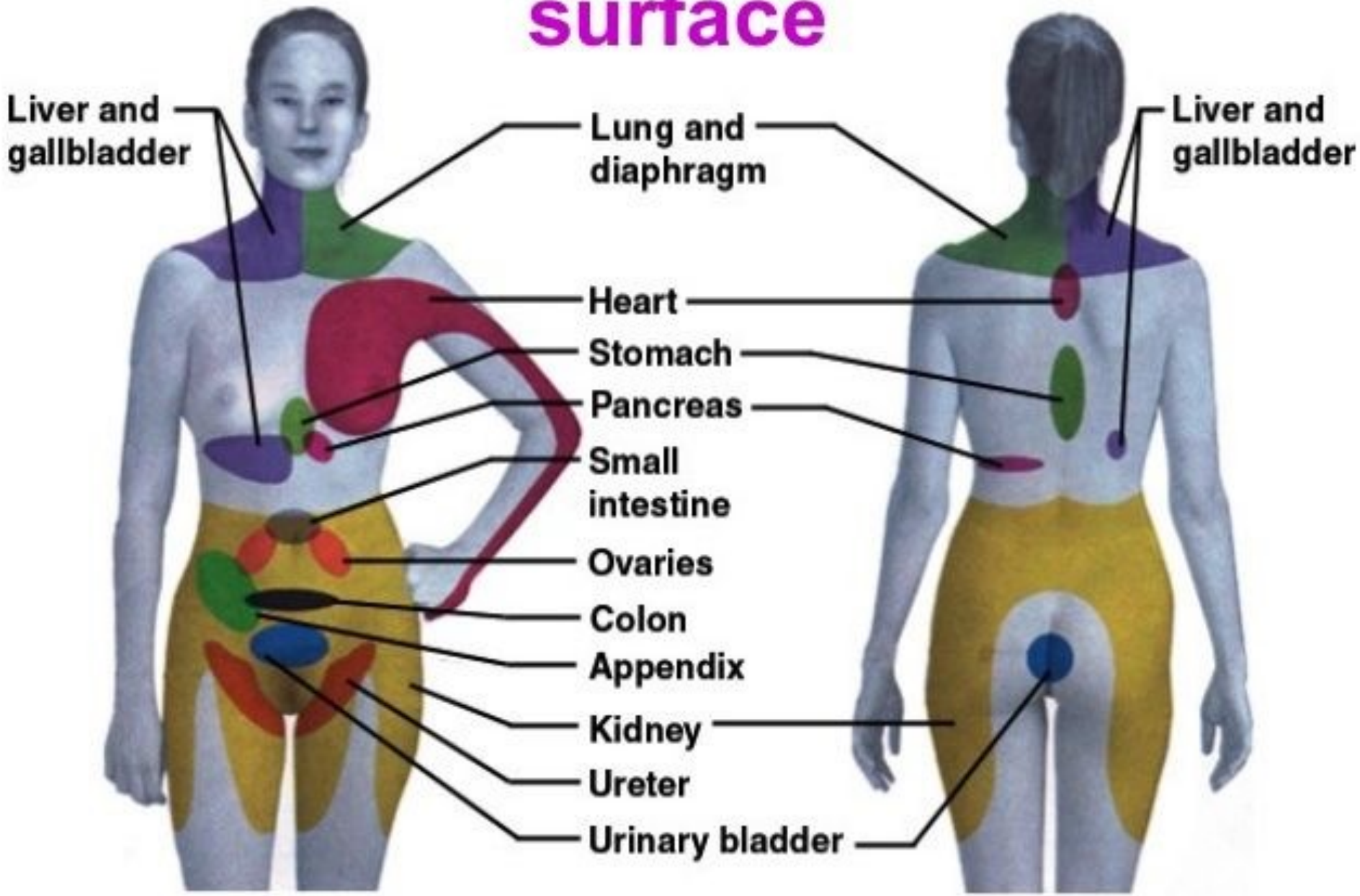
Q - Quality of the Pain

- What does it feel like?
- Can you describe?
- Examples provided below:
  - Nociceptive (Sharp, aching, throbbing)
  - Neuropathic (Shooting, burning, tingling, painfully numb)
  - Allodynia/hyperalgesia

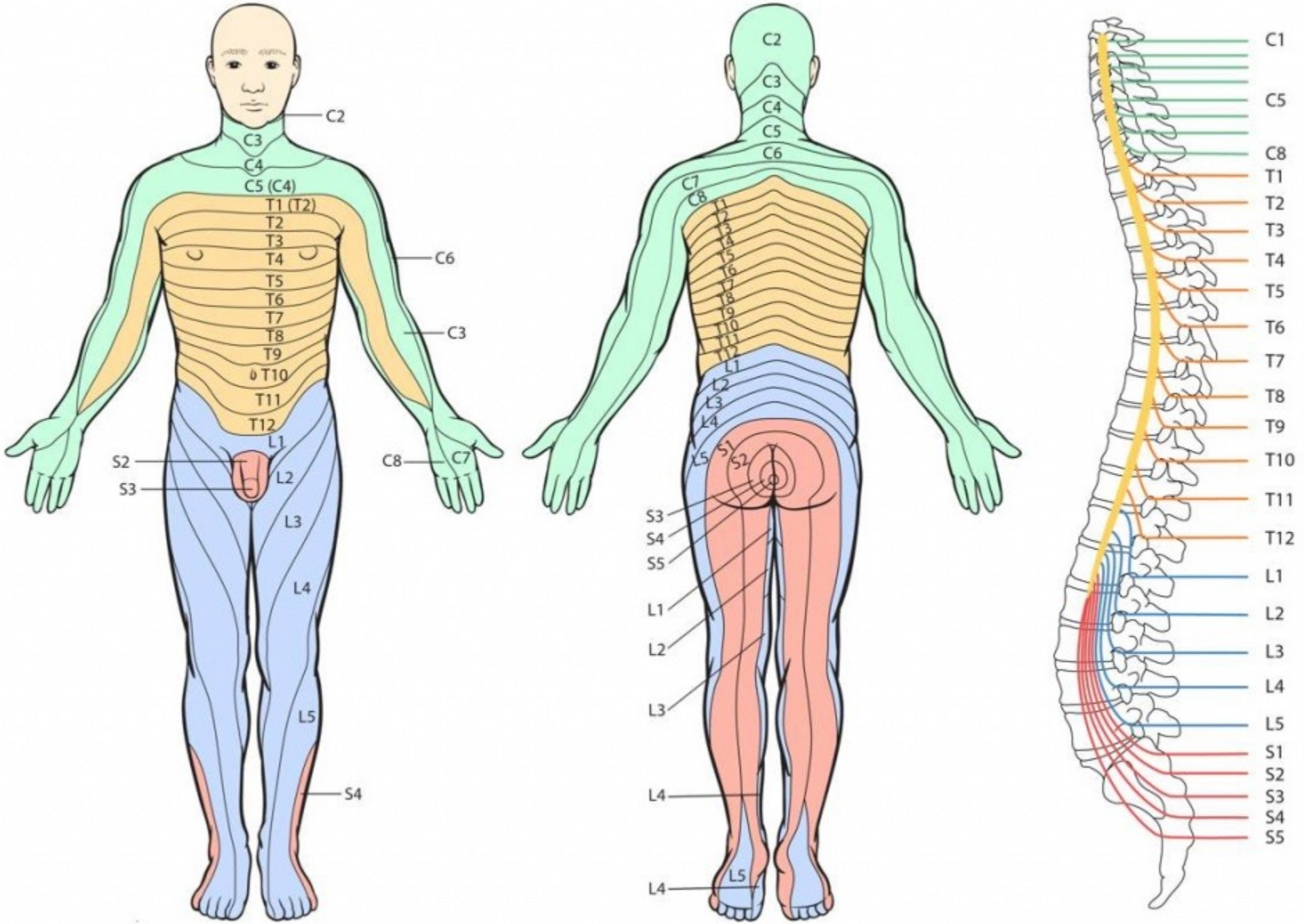
R - Region and Radiating

- Where is it?
- Does it spread anywhere?

Referred Pain-felt on the body surface



(chiro2016)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S3
S4
S5

(Physio 2010)

S - Severity/Intensity

- What is the intensity of this symptom?
- Right now?
- At best?
- At worst?
- On average?

T - Treatment and Timing

- What medications or treatments are you currently using?
- What medications have you tried in the past for this, and how well did they work?
- Do you/did you have any side effects from the medications/treatments?

U - Understanding

- What do you believe is causing this symptom?
- How is this symptom affecting you, your level of functioning and/or your family?

V - Value

- What is your goal for this symptom?
- What is your comfort goal or acceptable level for this symptom?
- Are there any other views or feelings about this symptom that are important to you and your family?

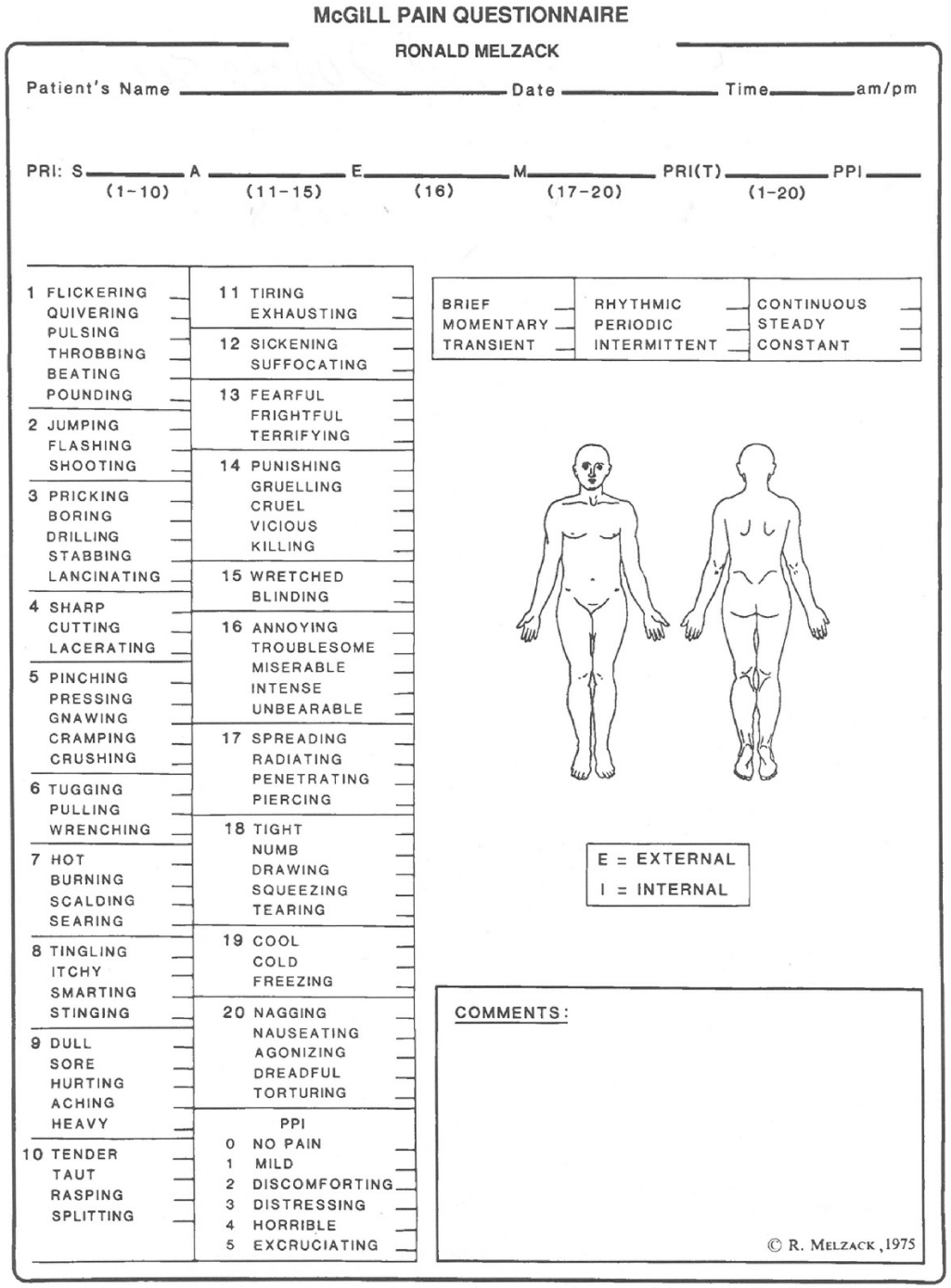
McGill Pain Questionnaire

- Works with a number of diagnosis
- Assesses quality and intensity of pain including sensory and affective components
- Long to complete which is a limitation in its use (78 descriptor words)
- May help the clinician in identifying the specific type of pain syndrome (i.e. neuropathic)
- Not ideal for repeated use in an acute pain setting
- There is a short-form version of the McGill Questionnaire that only has 15 descriptor categories.

Anderson, 2023)

McGill Pain Questionnaire

(Torgerson, 1970)



McGILL PAIN QUESTIONNAIRE

RONALD MELZACK

Patient's Name _____ Date _____ Time _____ am/pm

PRI: S _____ (1-10) A _____ (11-15) E _____ (16) M _____ (17-20) PRI(T) _____ (1-20) PPI _____

1 FLICKERING QUIVERING PULSING THROBBING BEATING POUNDING	11 TIRING EXHAUSTING	
2 JUMPING FLASHING SHOOTING	12 SICKENING SUFFOCATING	
3 PRICKING BORING DRILLING STABBING LANCINATING	13 FEARFUL FRIGHTFUL TERRIFYING	
4 SHARP CUTTING LACERATING	14 PUNISHING GRUELLING CRUEL VICIOUS KILLING	
5 PINCHING PRESSING GNAWING CRAMPING CRUSHING	15 WRETCHED BLINDING	
6 TUGGING PULLING WRENCHING	16 ANNOYING TROUBLESOME MISERABLE INTENSE UNBEARABLE	
7 HOT BURNING SCALDING SEARING	17 SPREADING RADIATING PENETRATING PIERCING	
8 TINGLING ITCHY SMARTING STINGING	18 TIGHT NUMB DRAWING SQUEEZING TEARING	
9 DULL SORE HURTING ACHING HEAVY	19 COOL COLD FREEZING	
10 TENDER TAUT RASPING SPLITTING	20 NAGGING NAUSEATING AGONIZING DREADFUL TORTURING	
	PPI 0 NO PAIN 1 MILD 2 DISCOMFORTING 3 DISTRESSING 4 HORRIBLE 5 EXCRUCIATING	

BRIEF MOMENTARY TRANSIENT	RHYTHMIC PERIODIC INTERMITTENT	CONTINUOUS STEADY CONSTANT

E = EXTERNAL
I = INTERNAL

COMMENTS:

Brief Pain Inventory (BPI)

- Multi-dimensional like the McGill Pain Questionnaire
- Assesses pain and how it affects them including the intensity, location, how much it interferes with daily life and how much pain a person experiences within a certain time frame (good with chronic longer lasting pain syndromes)
- This tool also looks at how long the pain lasts as well as pain medications
- Takes more time to complete vs single rating scales

(Anderson, 2023)

Brief Pain Inventory (BPI)

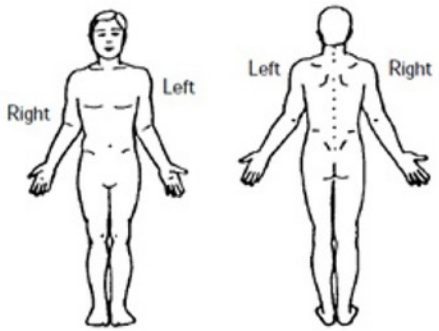
Date: ____/____/____ Time: _____

Name: _____ _____ _____
Last First Middle intial

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?

1. Yes 2. No

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



3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on **average**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

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

_____

_____

8) In the past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one 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) Circle the one 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

(Anderson, 2023)

Verbal Rating Scales

- Easy to understand and use
- Provides reliable information
- Less sensitive to visual analog scales
- This can lead to miscommunication and may involve difficulty with language barriers

(Clemens, 2020)

Verbal Rating Scales

(Clemens, 2020)

Numerical Rating Scales

- The horizontal line marked with the numbers from 1-10
- A person says or marks on the tool which number best represents their level of pain
- Easy to use with adults without cognitive impairments
- More specific than scales that use less than 10 numbers
- Some from specific cultures may prefer visual scales

(Clemens, 2020)

Numerical Rating Scales

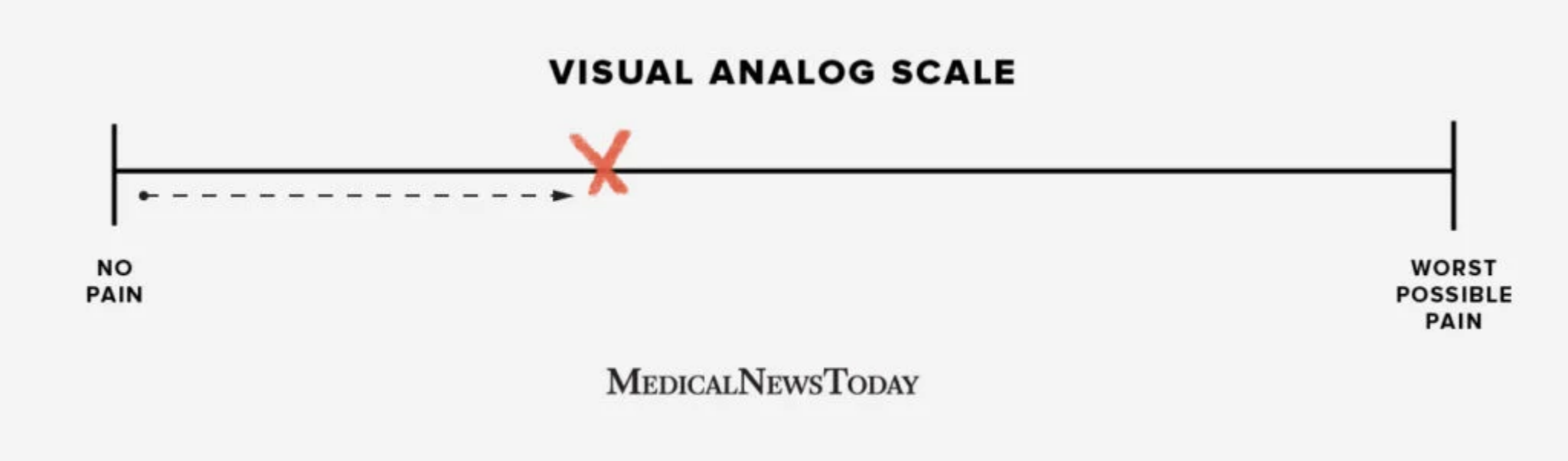
(Castiello, 2022)

Visual Analog Scales

- Vary in appearance
- Simple wording from no pain to severe pain on opposite ends of the tool
- Person marks a point between the two extremes to demonstrate how much pain they have (precise pain level)
- Useful for those with long-term pain conditions with pain levels that vary over time
- Some people may have difficulty with this particular tool if there are no labels or descriptors in addition the healthcare worker may have some issues with interpreting the results

(Clemens, 2020)

Visual Analog Scales



(Weatherspoon, 2020)

Additional Areas of Assessment

- **Physical Assessment**: site of each pain, intensity and severity of each pain, timing of pain, etc.
- **Pertinent history (risk factors)**: analgesic drug history, multiple cancer mechanisms, premorbid psychiatric conditions, etc.
- **Psychosocial and Spiritual Assessment**: assess for psychosocial or spiritual distress, coping deficits, i.e. psychogenic effects
- **Risks for Addictions**: history of alcohol or drug abuse, family history of alcohol or drug misuse

Pain Assessment Tools for the Cognitively Impaired

- Wong-Baker Faces
- PAINAD
- ABBEY
- DOS-2
- FLACC

*** Please follow your organization's policies on assessment tools*

Pain Assessment Tools for Cognitively Impaired

Task:
Correlate behaviours to determine if they are related to pain.

Look for :

- **Changes** in behaviour
- **Trends/Timing** of the behaviour
- Other likely **causes** for the behaviour

Pain Assessment In Advanced Dementia (PAINAID)

- For use in older adults with dementia or other cognitive impairments who are unable to reliably communicate their pain
- This tool requires the assessor to observe the patient for 3-5 minutes during an activity or movement like bathing or transferring
- The current score should be compared to the previous one as an increased in score would indicate an increase in pain and vice versa if the score decreases.
- Behaviours and observations should be considered alongside your knowledge of the existing painful conditions the person has.

Pain Assessment In Advanced Dementia (PAINAID)

	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 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

Warden, Hurley, Volicer, JAMDA 2003; 4(1): 9-15
Developed by the Geriatric Research Education Clinical Center (GRECC), VAMC, Bedford, MA

Oklahoma Foundation for Medical Quality
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Provided by the Oklahoma Foundation for Medical Quality, the Medicare Quality Improvement Organization for Oklahoma, under contract with the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 1A-106-PAD-OK-050106.

FLACC Pain Tool

- Was originally created for young children but has been proven to work with anyone with communication difficulties
- Stands for
  - F = Facial expression
  - L = Leg extension or relaxation
  - A = Activity (still or moving with pain)
  - C = Crying
  - C = Consolability
- Scoring:
  - 0 = relaxed/comfortable
  - 1-3 = mild discomfort
  - 4-6 = moderate pain
  - 7-10 = severe pain

(Jacques, 2022)

FLACC Pain Tool

FLACC scale (Face, Legs, Cry, Activity Consolability scale)	Score
Face 0- No particular expression or smile 1- Occasional grimace or frown, withdrawn, disinterested 2- Frequent to constant frown, quivering chin, clenched jaw	
Legs 0- Normal position or relaxed 1- Uneasy, restless, tense 2- Kicking or legs drawn up	
Activity 0- Lying quietly, normal position, moves easily 1- Squirming, shifting back and forth, tense 2- Arched, rigid, or jerking	
Cry 0- No cry (awake or asleep) 1- Moans or whimpers; occasional complaint 2- Crying steadily, screams or sobs, frequent complaints	
Consolability 0- Content, relaxed 1- Reassured by occasional touching, hugging, or being talked to; distractile 2- Difficult to console or comfort	
Total score (0-10)	

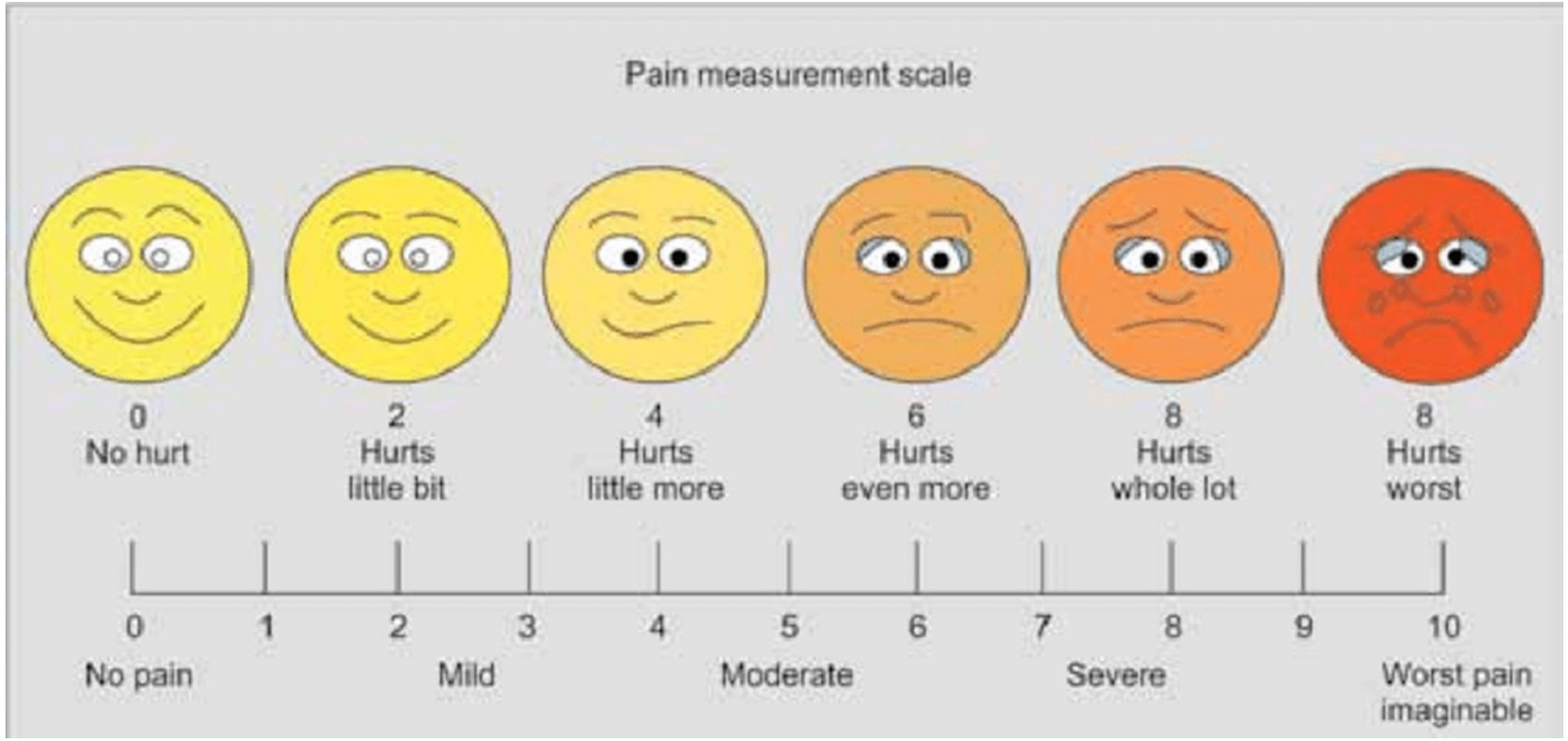
(Jacques, 2022)

Wong Baker Faces Tool *(Facial Expression Tool)*

- Most popular simple-to-use tool
- Different versions including one that has descriptor words and the numerical scale
- The faces on the tool are not what the person looks like it is how they are feeling inside
- Can be utilized for anyone with communication difficulties, including pediatrics and ventilated patients who may be awake
- Can also be confusing to some people like children and cognitively impaired as they may misinterpret the facial expressions as emotions

(Clemens, 2020)

Wong Baker Faces Tool *(Facial Expression Tool)*



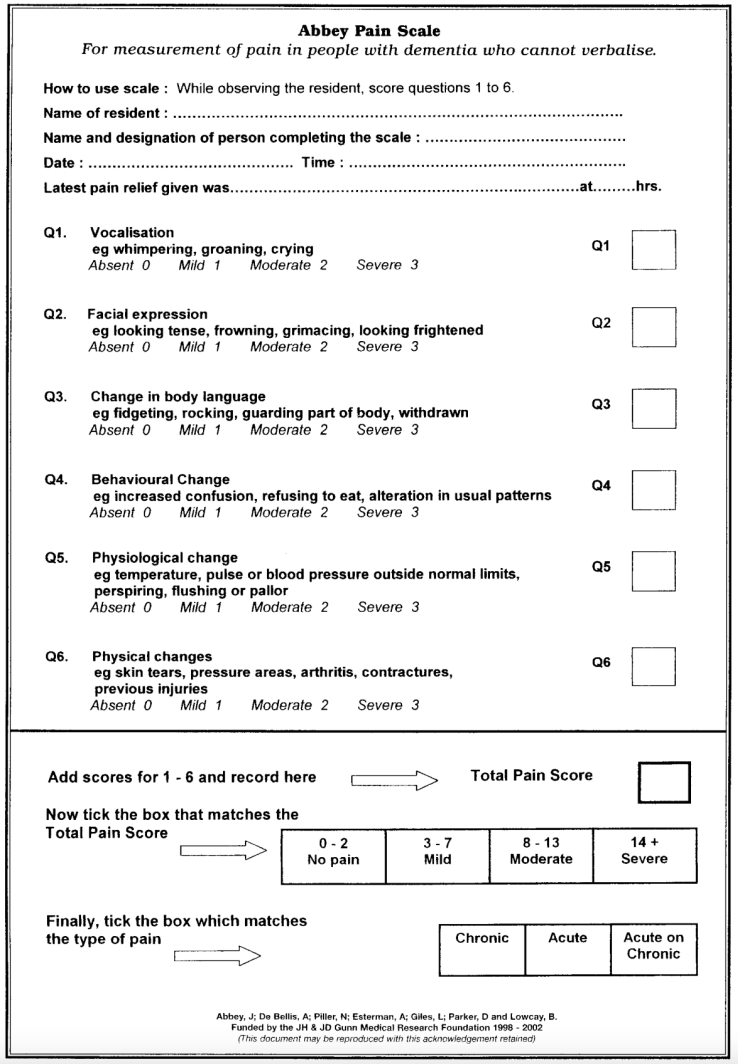
Researchgate.net

ABBEY Pain Scale

- This tool is used with those persons with dementia who are non-verbal
- Easy to use, no training required for the assessor
- Looking at particular behaviours and scoring based on the particulars of the behaviours
- Not a great deal of evidence with this tool because of whom this tool is primarily used for but researchers recommend its use

(Physiopedia, 2019)

ABBEY Pain Scale



Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale : While observing the resident, score questions 1 to 6.

Name of resident : .....

Name and designation of person completing the scale : .....

Date : ..... **Time :** .....

Latest pain relief given was.....**at**.....**hrs.**

Q1. Vocalisation
eg whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3
Q1 ☐

Q2. Facial expression
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3
Q2 ☐

Q3. Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3
Q3 ☐

Q4. Behavioural Change
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3
Q4 ☐

Q5. Physiological change
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3
Q5 ☐

Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3
Q6 ☐

Add scores for 1 - 6 and record here ⇨ **Total Pain Score** ☐

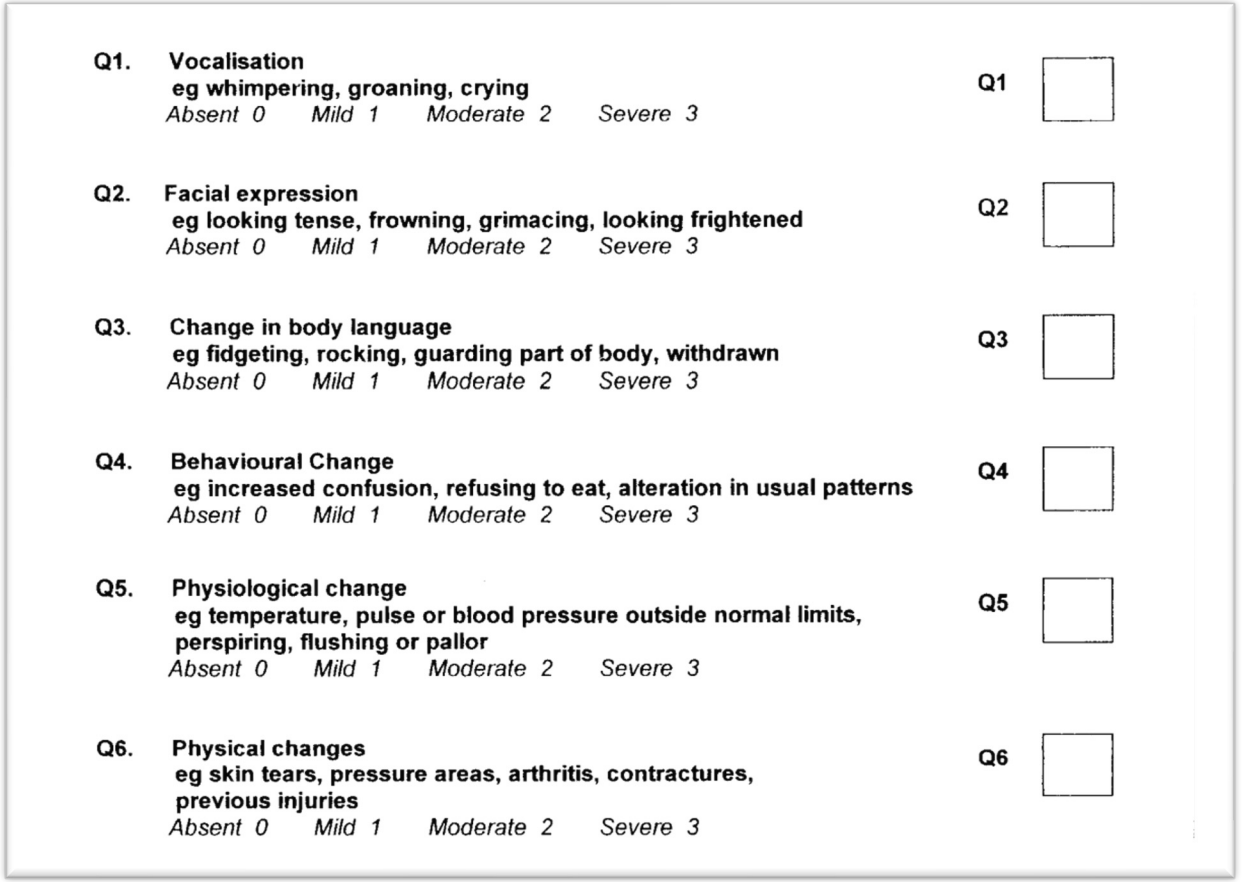
Now tick the box that matches the Total Pain Score ⇨

0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe

Finally, tick the box which matches the type of pain ⇨

Chronic	Acute	Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002
(This document may be reproduced with this acknowledgement retained)



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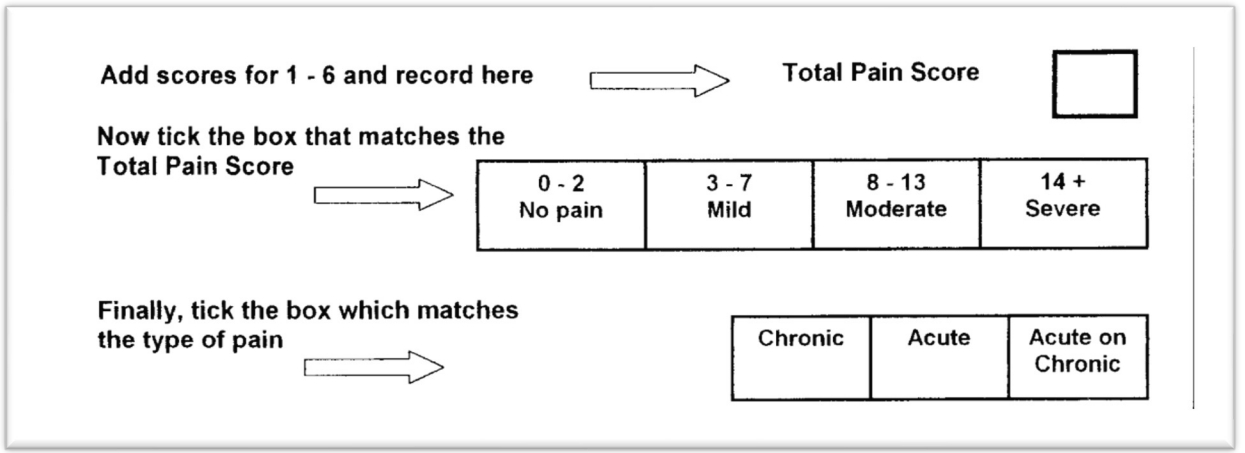

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Finally, tick the box which matches the type of pain ⇨

Chronic	Acute	Acute on Chronic

https://prc.coh.org/

Head-to-Toe Physical Assessment Related to Pain

- Touch: palpation of organs or masses
- Listening: lung and bowel sounds
- Observing: looking for deformities, areas of discolouration of the skin
- Looking for pain radiation sites

What does the Assessment Tell Us?

- An additional assessment may be needed.
- Outcome data from the assessments will aid in deciphering treatment options.
- How often assessments should be done.
- Is there a new pain?
- Is there an increase in the patients typical pain?
- Is there a new or different effect on the patient's ADLs, behaviour or mobility?
- Is there a change in the use of PRN medication (increased number of doses, doses being given closer together than before, doses clustered around certain times of day or a certain activity?)

Why is a Comprehensive Pain Assessment the key to effective pain management?

- A process is in place to ensure continuous re-evaluation, and to ensure that we do not miss important pieces in the pain story
- Requires interdisciplinary care that incorporates a thorough assessment toward developing a multimodal treatment plan
- Optimally, the plan includes pharmacological and non-pharmacological therapies

Documentation of the Pain Assessment

Always document according to facility policy and regulated professional college (if applicable) for your discipline.

- Thorough documentation should include:
  - Objective data (pain assessment tool used, results of pain assessment, any other measurable data)
  - Subjective data (personal observations, observations from other disciplines reported to you)
  - Who the information was reported to (nursing, MD/NP)
  - Interventions used (including nonpharmacological interventions)
  - Effectiveness of interventions and next steps
  - Who the effectiveness was reported to and any further changes to the plan of care

Case Study

Project ECHO® Palliative Care - Canada BY Pallium Canada

NSMHPCN North Simcoe Muskoka Hospice Palliative Care Network

Host and Moderator: Amanda Tevelde

Presenters: Julie Leighton-Phelps
Inge de Bruijn

Date: Thursday, June 29th, 2023

Case Study: John (Cognitively Intact)

- **Age:** 74 years old
- **Diagnosis:** metastatic prostate cancer to bone and lungs
- **PPS:** 40%
- **Concerning symptoms:**
  - Pain
  - Fatigue
  - Weight loss
  - Decrease appetite
  - Dyspnea, productive cough with occasional blood (hemoptysis)
  - Depression
  - Constipation

John lived alone. He received community support from PSWs and nurses. The family provided food and transportation to appointments but he was alone most of the time.

John's status deteriorated and he was transferred to hospice. While at the hospice, John improved! His appetite improved, he enjoyed the social aspect of being at the hospice, benefited from spiritual support and bereavement counselling. His symptoms were well managed.

While at Hospice John and his family's expectations/goals for care, were to be supported in his final days with good symptom management, in a caring environment.

As John’s disease progressed, he began to decline and his symptoms became more troublesome. John’s reporting of pain increased. Staff noted grimacing with movement. John slept more and his oral intake decreased.

A comprehensive pain assessment was completed and the results were shared with the patient, family and care team.

Case Study: Mark (Cognitively Impaired)

- **Age:** 74 years
- **Primary Diagnosis:** stroke in 2019 resulting in some right-side weakness, reduced range of motion and communication difficulties, vascular dementia from the stroke
- **Other Diagnoses:** Type 2 diabetes, high blood pressure, depression, arthritis
- **Other information:**

- Is widowed (his wife died in 2021, and was his primary caregiver)
- Is now supported by HSW/PSW for assistance with his ADLs and resides in a Retirement Home

Mark is usually able to communicate with staff using short sentences and answering yes/no questions. He smiles at staff when they speak to him but he has trouble initiating speech/conversation.

Mark's usual demeanour is pleasant, although since his wife died, he has been more withdrawn and often looks sad according to staff.

Mark is able to ambulate independently with his walker but is a high risk for falls because he often leaves it behind and moves about without it.

Mark’s POA is now his daughter (Jane) since his wife’s death

His daughter has expressed that her dad never talked about his wishes regarding healthcare prior to his stroke. She has expressed the wish that he “be comfortable in his golden years”. She also feels that her Dad is “tough” and never complained about anything his entire life.

As a staff member, you have interacted with Mark briefly at breakfast and lunch to give him his medication.

Now in mid-afternoon, John is sitting in his favourite spot – the chair beside the nurse's desk. You greet him and he begins to stand and come towards you. Mark can be slow to stand up due to the effects of his stroke, it often takes him multiple tries to go from sitting to standing but different today you notice him **frowning and grimacing** during the process.

When asked if he is ok, he answers "Yes!". You aren't so sure.

You decide to do some investigation and speak to the team

The PSW who assisted Mark with his morning care reports that Mark was very resistant to care and was quite vocal during dressing. The PSW described it as **low moaning or groaning**. The PSW states that the **behaviour has been increasing** over the last week or so and is not typical of Mark.

The dietary aide who served Mark lunch noticed that he **hardly ate** any of his meals today and his **appetite has been poor for a few days.**

This morning, Mark went to physical therapy. The PT tells you that John was quite **fidgety**. He didn't sit still and kept **rubbing his right thigh**. He was resistant to any assistance from the PT assistant to complete the exercises and stretches, **pushing away the hands** of the assistant.

Armed with this information, you decide to complete a **pain assessment** on John. You believe that due to his **communication difficulties** and his dementia, you would not be able to complete the OPQRSTUV pain assessment appropriately.

1) **What pain assessment tool could you use instead to determine whether John is having increased pain?**

2) **Could you still use the OPQRSTUV pain assessment?**

1) Is he in increased pain?

2) What type(s) of pain is John experiencing?

3) What are the next steps?

4) How would you communicate this information to the MD? To the POA?

You speak to the MD, who agrees that John is likely experiencing an increase in pain. The doctor has made changes to Mark's medications. The trial is to last 1 week and then the results communicated to the MD.

You call Jane to inform her of the new orders and discuss the results of the pain assessment. She has some concerns about whether Mark is actually in pain and the side effects of the new medication. You review the pain assessment tool used, and the results, and discuss her concerns. She agrees to the trial.

Mark begins his new medication regime the next morning.

1) **When should a follow-up pain assessment be completed to see if the new regime is managing his pain?**

2) **After the trial, does a pain assessment need to be completed regularly or just when John shows signs of pain?**

3) **What else do we need to consider?**

Tips and Reminders about Pain Assessment

- Remember pain is whatever the person says it is and not what the clinician feels it is
- Communication is the key
- It is important to be aware of cultural and religious backgrounds
- Patients' previous pain experiences will be indirectly associated with their current pain experience and how they will respond to assessments
- Important to educate the patient and families regarding the reason why pain assessments and the need for treatments are imperative for their overall well being

Summary

1) A palliative approach to care ensures the highest quality of life, no matter where a person is on their disease trajectory
2) A palliative approach to care is a team effort and requires excellent communication and teamwork
3) Pain can be assessed with the use of an appropriate tool, even with someone who is nonverbal or cognitively impaired
4) Thorough assessment, documentation and communication within/between the care team will recognize changes in status and offer a timely response for intervention, improving quality for the individual, minimizing adverse events

Resources

- Pallium Canada
- Pallium Palliative Pocketbook
- RNAO Best Practice Guidelines for Pain and LTC toolkit
- Cancer Care Ontario (CCO) Pain
- Virtual Hospice
- De Souza: Advanced Pain Assessment and Management Course
- IASP: International Association For the Study of Pain

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Thank you for joining us today!

Please remember to complete the satisfaction survey following todays session.