Pain Assessment

Introduction

All nurses have the ethical responsibility to assess and relieve pain utilizing individualized interventions and plan of care, free of personal biases (ANA, 2018). To assess pain adequately and accurately, a multidisciplinary, measurement-based approach is best.

Types of Pain (Dydyk & Grandhe, 2023)

- Nociceptive pain originates in the peripheral nervous system and then travels to the central nervous system creating a pain sensation once the threshold has been achieved.
- Chronic pain occurs when acute pain is present for three to six months and becomes centralized. Centralized pain occurs with a lower threshold resulting in a maladaptive form of pain.
- Neuropathic pain is the dysfunction of the somatosensory tract of the nervous system and can be both peripheral and centralized pain. Neuropathic pain can be a factor in the development of chronic pain.

History

- Elicit details about the history of the pain including location, timing (onset, duration, frequency), quality or severity, factors that worsen or alleviate the symptom, and associated manifestations.
- Ask the patient to describe the pain and how it started.
- Ask if the pain is acute or chronic.
- Ask if the pain is related to an injury or if it's associated with a certain movement.
- Have the patient describe the quality of the pain. Is it sharp, dull, or burning?
- Ask if the pain radiates or follows a certain pattern.
- Ask what makes the pain better or worse.
- Perform a comprehensive medication history. Ask about both prescribed medications and over-the-counter pain medications.
- Inquire about any other treatments the patient has tried, such as medical marijuana, physical therapy or alternative therapies.
- Ask about any co-existing conditions that may impact pain, such as arthritis or diabetes, and recent or past injuries.
- Find out how the pain affects the patient's daily activities, mood, sleep, work, and sexual activity.

Assess Pain Severity

- Use a consistent method to assess severity of the pain.
- Pain scales that are commonly used include:
    - the Visual Analog Scale (VAS)
        - horizontal line with verbal description at each end
        - patient marks the point on the line that best describes their severity
    - the Numeric Rating Scale (NRS)
        - zero to ten scale
        - patient indicates number that best correlates to their pain
    - the Wong-Baker FACES® Pain Rating Scale
        - six faces with different facial expressions ranging from "no hurt" to "hurts worst"
        - patient can point to picture that represents their pain level
        - commonly used with children or patients with language barrier or cognitive impairment

Physical Examination

- Ask the patient to point to the pain.
- Be alert for changes in vital signs: elevated blood pressure, heart rate, or respiratory rate.
- Throughout the physical examination, look for signs of distress: increased respiratory rate, sweating, tearing, and changes in facial expression.
- Tailor your assessment based on the location and severity of the pain.

Pediatric Considerations (Wrona & Czarnecki, 2021)

Choose the correct pain scale tool based on age/developmental stage.

- Neonates and infants
    - Premature infant pain profile (PIPP) for less than or equal to 37 weeks gestation
    - Neonatal Infant Pain Scale
    - Face, Legs, Activity, Cry, Consolability (FLACC) scale
    - Child Facial Coding System
    - Crying, requires increased oxygen administration, increased vital signs, expression, sleeplessness (CRIES) score
    - Children's Hospital of Eastern Ontario Pain Scale
    - Riley Infant Pain Scale
    - Children and Infants Postoperative Pain Scale

- Toddlers
    - Faces Pain Scale-Revised (FPS-R)
    - Wong-Baker FACES pain rating scale
- School age and adolescent
    - Numeric rating scales are easy to use and may be verbal (Verbal Numerical Rating Scale) or written (Visual Analogue Scale)

PEARLS

- Patients who are nonverbal or unresponsive can still experience pain. Note changes in vital signs, facial expression, level of agitation or withdrawal to guide pain assessment and management.
- A pain diary can be used to complement the history and physical examination.

References:

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Pediatric Considerations (Wrona and Czarnecki, 2021)

- Choose the correct pain scale tool based on age/developmental stage
    - Neonates and infants: Premature infant pain profile (PIPP) for ≤ 37 weeks gestation, Neonatal Infant Pain Scale, the FLACC (Face, Legs, Activity, Cry, Consolability) scale, Child Facial Coding System, CRIES (Crying, Requires increased oxygen administration, Increased vital signs, Expression, Sleeplessness) score, Children's Hospital of Eastern Ontario Pain Scale, Riley Infant Pain Scale, and Children and Infants Postoperative Pain Scale.
    - Toddlers: use face scales such as the Faces Pain Scale-Revised (FPS-R) and Wong-Baker FACES pain rating scale
    - School age and adolescent: use Numeric rating scales are easy to use and may be verbal (Verbal Numerical Rating Scale) or written (Visual Analogue Scale).

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- Patients who are nonverbal or unresponsive can still experience pain. Note changes in vital signs, facial expression, level of agitation or withdrawal to guide pain assessment and management.
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References

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