Pain Module

Pain Assessment in the Adult Patient Unable to Self-Report (Nonverbal or Cognitively Impaired)
The potential for unrelieved and unrecognized pain is the greatest in those who have difficulty communicating.

Obtaining reports of pain may be hampered by:

– delirium,
– cognitive and communication limitations,
– level of consciousness,
– presence of an endotracheal tube,
– sedatives,
– neuromuscular blocking agents (motor is blocked, but sensory is intact).

• **Always try to elicit a self-report from patient.** If he/she is alert, but unable to talk, try having him/her point to a number on the 0-10 pain scale, nod, blink, etc. Be Sure to let others know what method is successful.

• Observe the patient’s behaviors.

• Consider asking those who know the patient well to assist in determining if the non-verbal patient is experiencing pain.

• **DOCUMENT!**
When in Doubt:
Assume Pain is Present and Treat

- Identify pathologic conditions or procedures that may cause pain in your non-verbal or cognitively impaired patient.
- **Assume Pain is Present (APP)** and treat if the same procedure or condition is normally considered painful.
- Confer with prescriber and thoroughly document your observations and rationale for treatment.
How would you know if a nonverbal patient is having pain?

- **Facial expression**
  - Distortion, grimacing, frowning, wincing, clenching teeth, tightening of lips, skin drawn around eyes/mouth, wrinkling forehead, tearing

- **Body Language**
  - Cautious or hesitant movement, rocking, restless, withdrawal reflex, clutching painful area, thrashing, pounding, biting, kicking, massaging, rubbing guarding, applying pressure, assuming a specific position, panting, tensing, rigid, resistance to passive movements

- **Vocalizations**
  - Ouch, moaning, groaning, grunting, sighing, gasping, crying, screaming, sobbing, swearing, praying, counting, oye-oye-oye, aïe-aïe-aïe

- **Other**
  - Vital sign changes (elevated or depressed). Typically absent in chronic pain.
  - Diaphoresis
  - Fighting the ventilator

- Note that patients who are paralyzed or unconscious will not be able to express themselves in all categories of behaviors.
Using Behavioral Pain Scales

Many tools have been developed and studied. Tools are used to assess either physiologic and/or behavioral indicators of pain. As opposed to a self-report, the presence of pain and estimates of severity are decided by someone other than the patient. There are no perfect tools or methods to assess pain in someone who can’t talk to you.

• Most behavioral pain scales address the patient’s
  – face
  – body language
  – vocalizations

• Behavioral observations may or may not be related to pain. The behaviors could also indicate anxiety, confusion, frustration, fear, and/or depression.

• Patients may be experiencing severe pain, yet because of exhaustion or something else, they are not able to display pain-like behaviors.

• Sleep and sedation do not equate with the absence of pain or with pain relief.

• A number obtained on a behavioral tool is NOT equivalent to the self-report 0-10 pain severity number.

• Examples of some tools follow on the next slides.
Behavioral tools for non-verbal infants and children

• Neonatal Infant Pain Scale (NIPS) (Lawrence, et al, 1993)
  – Scores the following: facial expression, cry, breathing patterns, arms, legs, and state of arousal are assessed and scored.

• N-PASS
  – Used to assess term and preterm infant pain and sedation.
  – Scores assigned to crying/irritability, behavior state, facial expression, extremities/tone, and vital signs.

• CRIES (Krechel & Bildner, 1995)
  – Used to assess acute pain
  – Scores assigned to crying, requires oxygen, increased vital signs, expression, sleep

• FLACC (Merkel et al, 1997)
  – Developed to assess postoperative pain in young children.
  – Scores five behaviors, face, legs, activity, cry, consolability

• Usually, by the age of 4 or 5, children are able to use the 0-10 scale in the FACES format or the usual verbal format to self-report their pain.

• Some BHSF entities have chosen tools to use for certain ages e.g., neonate, newborn, non-verbal toddler. See the entity’s pain policy for details.
Example of a behavioral tool for critically ill adult patients

• The Critical-Care Pain Observation Tool (CPOT) is one of the few behavioral pain scales which has been developed and validated for the purpose of detecting pain in nonverbal critically ill adults.

• The tool evaluates facial expression, body movements, compliance with ventilator for intubated patients, vocalization, and muscle tension. Note that this tool separates body language into 2 separate sections—body movements and muscle tension.

• Tool follows on next slide.
## The Critical-Care Pain Observation Tool (CPOT)
(Gelinas et al, 2006)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FACIAL EXPRESSION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed, neutral</td>
<td>0</td>
<td>No muscle tension observed</td>
</tr>
<tr>
<td>Tense</td>
<td>1</td>
<td>Presence of frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during nociceptive procedures)</td>
</tr>
<tr>
<td>Grimacing</td>
<td>2</td>
<td>All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)</td>
</tr>
<tr>
<td><strong>BODY MOVEMENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of movements or normal position</td>
<td>0</td>
<td>Does not move at all (doesn’t necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)</td>
</tr>
<tr>
<td>Protection</td>
<td>1</td>
<td>Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements</td>
</tr>
<tr>
<td>Restlessness/agitation</td>
<td>2</td>
<td>Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed</td>
</tr>
<tr>
<td><strong>COMPLIANCE WITH THE VENTILATOR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(intubated pt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerating ventilator or movement</td>
<td>0</td>
<td>Alarms not activated, easy ventilation</td>
</tr>
<tr>
<td>Coughing but tolerating</td>
<td>1</td>
<td>Coughing, alarms may be activated but stop spontaneously</td>
</tr>
<tr>
<td>Fighting ventilator</td>
<td>2</td>
<td>Asynchrony: blocking ventilation, alarms frequently activated</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VOCALIZATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(non-intubated patient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking in normal tone or no sound</td>
<td>0</td>
<td>Talking in normal tone or no sound</td>
</tr>
<tr>
<td>Sighing, moaning</td>
<td>1</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td>Crying out, sobbing</td>
<td>2</td>
<td>Crying out, sobbing</td>
</tr>
<tr>
<td><strong>MUSCLE TENSION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relaxed</td>
<td>0</td>
<td>No resistance to passive movements</td>
</tr>
<tr>
<td>Tense, rigid</td>
<td>1</td>
<td>Resistance to passive movements</td>
</tr>
<tr>
<td>Very tense or rigid</td>
<td>2</td>
<td>Strong resistance to passive movements or incapacity to complete them</td>
</tr>
<tr>
<td><strong>TOTAL SCORE</strong></td>
<td>_____/8</td>
<td>(This number does not equate to the verbal 0-10 self-report scale, although the numbers indicate degrees of distress.)</td>
</tr>
</tbody>
</table>
Choosing Pain Assessment Tools

• The choice of a scale should be based on validity, reliability, consistency, usefulness, the population to be assessed, the ease of use, and determination of how the information will be used to treat the patient.

• Published tools should not be modified. Doing so may jeopardize validity and reliability.

• Specialty areas across BHSF entities should collaborate to choose tools e.g., critical care, NICU etc.
Summary

• Obtain **Self-Report** if possible.
• Search for Potential Causes of Pain (APP).
• Observe Behaviors (Face, Body Language, Vocalizations).
• Use a behavior tool if one has been agreed on by your entity.
• Involve those who know patient well to assist.
• Attempt Analgesic Trial (APP).
• Document all of the above.

**Key Reference for this Module:**