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Pain Assessment

ONGOING PAIN VIGILANCE
'See change, think pain'

PAIN THERAPEUTIC CULTURE
Pain prevention and pain treatment

1. Pain Identification

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2. Pain Assessment

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3. Pain Treatment

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4. Monitoring and Evaluation

Key summary

- **Pain assessment** aims to measure pain, understand the cause of pain, and how the resident experiences pain and is impacted by it.
- Ongoing pain assessment and continuous pain vigilance is important for optimal pain management.
- Pain assessments can be conducted as part of routine care, or in response to new/changing pain being reported or identified. These may include an interview and physical examination.
- **Pain assessment** scales can be used to assess each residents' pain. Some scales are designed to be used with residents who can self-report, and others are designed to be used with residents who cannot communicate effectively.
- **Pain charting** can be used to monitor and document pain over a brief time period.

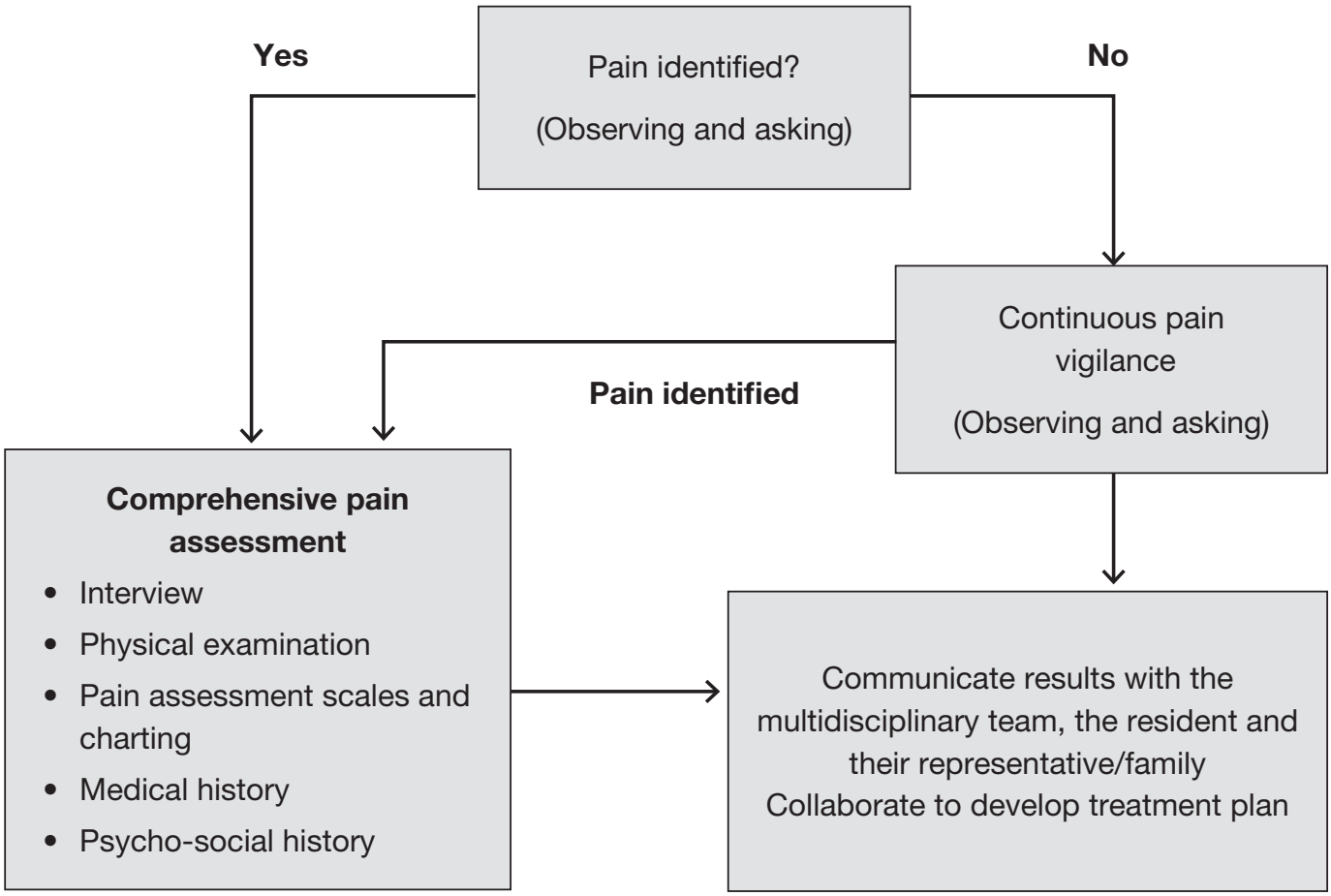
When to conduct a routine pain assessment

- On admission for every new resident.
- After any fall or near fall even if no immediate injury is present.
- After any injury, surgery, medical procedure or care regime that may be associated with pain.
- After any new diagnosis or progression of disease that may be associated with pain.
- If there are any changes to the resident's medical or physical condition.
- Every three months (e.g. with the Resident of the Day) or weekly for people living with dementia (using a quick assessment scale).

When to conduct a pain assessment triggered by pain identification or ongoing pain:

- As soon as any concerning or significant pain is identified or suspected, including reports from the resident, staff, or family/ representatives.
- Prior to any new pain treatment or medication.

How to do a pain assessment



Regular pain assessments should be conducted: on admission, when there is a significant change in a resident's condition or there is a potentially painful event, every three months, and at end of life.

Interviews

Staff should have a detailed discussion with residents about their pain experience. For residents who are unable to communicate successfully, a discussion should also involve their representative or family. An interview may include questions about:

- Location, duration, nature, severity, and frequency of pain.
- The impact of pain on e.g. sleep, appetite, moving around, doing usual activities or socialising.
- What the resident is hoping to achieve from the pain management process e.g. elimination of pain, ability to do certain activities without pain.

Physical examination

- Observes the severity of pain as well as when and how it presents.
- Is to be done by a nurse. Additional examinations can be done by a doctor, physiotherapist, or other health professional as needed.
- Is to be done while the resident is at rest as well as moving or being moved.

Pain assessment tools

There are many types of pain assessment tools available. Decisions about which one to use will depend on each resident as well as policies and procedures of each facility.

Self-report pain assessment tools (for those who can communicate)

- Allow residents to share their experience of pain.
- Are the gold standard of pain assessment.
- May be used for residents living without dementia or with mild to moderate dementia.
- Require careful and skilled communication with appropriate body language from staff.
- Can be used for initial pain assessment as well as for ongoing monitoring.

The following self-report assessment tools are commonly used. Copies are included in the Printable Resources.

Unidimensional scales

Numeric Rating Scale (NRS)
Residents rate their pain on a scale of 0-10, where 0 indicates no pain and 10 indicates the worst possible pain.

Verbal Descriptor Scale (VDS)
Resident categorises their pain with words, such as 'no pain', 'mild', 'moderate', 'severe', 'very severe' or 'worst possible pain'.

Multidimensional scales

Modified Resident's Verbal Brief Pain Inventory (M-RVBPI)
A bio-psycho-social scale developed for residential aged care. Residents rate pain severity and location. Residents also rate the physical and psycho-social impacts of pain on their general activity, mood, relations with others, walking ability sleep, and enjoyment with life. It can be used for the initial pain assessment as well as for ongoing monitoring.

Observational pain assessment tools (for those who are not able to communicate)

- Should be used for residents living with severe dementia or other conditions limiting their ability to communicate their experience of pain.
- These tools assess pain through observation of facial expressions and behavioural responses.

The following observational assessment tools are commonly used. Copies are included in the Printable Resources.

Pain Assessment in Advanced Dementia (PAINAD) Scale

Records severity of the following things after 5 minutes of observation under different conditions: breathing independent of vocalization, negative vocalization, facial expression, body language and consolability.

Abbey Pain Scale

Records the severity and frequency of observed vocalisations, facial expressions, changes in body language or behaviour, and any physiological or physical changes.

Charting

Each facility will have its own system for documentation and recording resident information. It is crucial for all information about a resident's identified pain and the outcomes of assessment to be consistently recorded in their file. A pain chart template that may be helpful in facilitating this is included as a Printable Resource.