Decision Support Resources:
Assessment & Management of Pain Order Set

Press CTRL then Click on the topic below for which you would like more information:

• International Classification for Nursing Practice (ICNP) Codes[1]

- ICNP is a standardized language for describing nursing data that uses a numerical coding system.
- ICNP codes enable organizations to extract meaningful data from their systems.
- Standardized data is essential in electronic systems to facilitate outcome evaluation and ongoing quality improvement.

• Screening For Pain in Adults

Screening For Pain in Persons Able to Self-Report[2]

The American Medical Directors Association (AMDA) guideline, Pain Management in the Long Term Care Setting (2012, p. 8), outlines questions that can be adapted to any population and used to detect pain in persons who are able to self-report such as:

- Are you feeling any aching or soreness now?
- Do you hurt anywhere?
- Are you having any discomfort?
- Have you taken any medications for pain?
- Have you any aching or soreness that kept you up at night?
- Have you had trouble with any of your usual day-to-day activities?
- How intense is your pain?

People are at risk for acute pain if they undergo procedures known to cause it, such as skin-breaking procedures, immunization, surgery or drainage tube insertion or removal. Rescreen for the presence or risk of any type of pain routinely as per organizational policy.

Screening For Neuropathic Pain (Self-Report)[2]

Early screening by the interprofessional team is important because diagnosing neuropathic pain may take more investigation to facilitate early management. Screening questionnaires for neuropathic pain include:

- Self-Report Leeds Assessment of Neuropathic Symptoms and Signs (S-LANSS)
- Douleur Neuropathique 4 (DN4)

Screening for Pain In Persons Unable to Self-Report[3]

The inability to describe pain does not mean a person is not experiencing it. Screening for pain in persons who are unable to self-report is critical to appropriate care.

- Attempt to have the person self-report allowing sufficient time to respond to a close-ended question requiring a simple yes or no answer.
- Behavioural cues such as nodding, pointing, groaning etc. is a valid way for a person to indicate the presence of pain.

• Assessing for Pain[3-4]

Assessing Pain in Persons Unable to Self-Report[3]

1. Validated, population- and context-specific behavioural pain scales are recommended when self-report is impossible.
2. Obtain proxy reporting from family or caregivers about potential behaviour that may indicate the presence of pain.
   - Family and caregivers' proxy reports of pain intensity alone have been shown to be inaccurate.
   - Combine proxy pain assessments with other information such as:

- Direct observation with validated behavioural pain scales;
- Person's diagnosis;
- Findings from their health history; and,
- Physical examination.

3. Vital signs (e.g. heart rate, blood pressure and respiratory rate) are only one aspect of a person's comprehensive pain assessment.
   - Vital signs do not discriminate pain from other sources of distress.

Comprehensive Pain Assessments (Self-Report)[4]

Pain is a multidimensional, subjective phenomenon. Therefore, a person's self-report is the most valid way of assessing pain if the person is able to communicate.

A comprehensive pain assessment uses a consistent, systematic approach:

- Self-report tools may be unidimensional (looking only at one aspect of pain such as intensity) or multidimensional.
- Multidimensional tools are particularly useful when a comprehensive pain assessment is required.
- This order set uses a multidimensional tool based on the acronym "OPQRSTUV" to assess persons with a positive pain screen and who are able to self-report. It is in the public domain.
- Refer to the RNAO Guideline, *Assessment and Management of Pain, Third Edition* (p. 23) for considerations when selecting a validated pain assessment tool and for a list of population-specific tools (Appendix E - p. 81).
- Pain assessment tools for older adults with cognitive impairment are listed in the RNAO Guideline, *Assessment and Management of Pain, Third Edition* [Appendix M] (p. 95).

A comprehensive pain assessment includes:

Pain Medication History
The pain medication history includes all current and relevant past prescription medications, non-prescription medications, and complimentary/alternative medications. For each medication or product include: dose, dosage form, frequency, route, indication, level of patient adherence, and the source of the information.

Impact of Personal Beliefs About Pain On Pain Assessment and Management
A person's beliefs about pain often influence whether they will seek help for it and what strategies they will accept to manage it. Misbeliefs about pain are often accepted as truth and are barriers to assessing and managing pain effectively. Nurses need to ask questions to uncover a person's beliefs and concerns about pain. Common misbeliefs and facts about pain assessment and management for adults and older persons are shown below.

- **Common Misbeliefs and Facts about Pain Assessment and Management for Adults and Older Persons[5]**

MISBELIEFS	FACTS
Pain is a normal part of aging and can never be very intense as pain sensation decreases with age.	Persistent pain is not a normal part of aging.
Pain cannot be assessed with older persons who are cognitively impaired.	The intensity and sensation of pain does not decrease in older persons.
People who are in pain always have observable signs that are more reliable than their own self-reports.	Inadequate pain management of potential or actual pain in older persons has numerous consequences.
People will verbalize when they are in pain and will use the term "pain".	Older people with mild to moderate cognitive impairment are able to use scales adapted for their needs such as categorical numerical scales.
People should expect to have considerable unrelieved pain with procedures such as surgery.	People will not necessarily verbalize when they are in pain and may not use the word pain.
People who use opioids for pain are addicts.	Unrelieved severe acute pain has physiological consequences involving various body systems and may cause long-term pain.
Pain is directly proportional to the tissue injury.	Physiological adaptations occur quickly and should not be used instead of self-report when the latter is available.

- **Pain Management Considerations for Older Persons[6]**

When planning pharmacological interventions, the impact of age-related changes such as co-morbidities, co-existent diseases and use of multiple medications must be considered, as they put the older adult at high risk for medication-related adverse events.

- The older adult may experience communication challenges associated with:
  - under reporting of pain;
  - language barriers; and,
  - communication barriers (aphasia, cognitive impairments such as dementia, visual and hearing impairments).

The plan of care should also reflect principles that maximize efficacy and minimize the adverse effects of

pharmacological interventions (e.g., Multimodal Analgesic Approach).

- **Multimodal Analgesic Approach**[7]

To maximize efficacy and minimize the adverse effects of a multimodal analgesic approach nurses and other health professionals should use the following principles to guide practice:

1. Use the most efficacious and least invasive way to administer analgesics.
2. Consider a multimodal analgesic approach to pain management:
    - Use non-opioids to manage mild to moderate pain;
    - Use opioids in combination with non-opioids to manage moderate to severe pain; and
3. Advocate for the most effective dosing schedule, considering the medication(s) duration of onset, effect(s) and half-life. The optimal analgesia dose is one that effectively relieves pain with minimum adverse effects.
4. Recognize potential contraindications (e.g. co-morbidities or drug-drug interactions).

- **Complex Pain Situations**[7]

Consider consulting the interprofessional team or pain-management experts for complex pain situations such as:

- Anxiety/depression/catastrophizing screening;
- Pain that does not respond to standard pain management interventions;
- Multiple sources of pain;
- Mixed neuropathic and nociceptive pain;
- History of substance use disorders; and
- Opioid-tolerant persons undergoing procedures or having exacerbations of pain.

- **Pain Management Planning Resources for Different Types of Pain**

Consult the following resources, as required, to develop a person-centred pain management plan that is appropriate for their type of pain:

Acute Pain

- See Multimodal Analgesic Approach in the previous section.

Neuropathic Pain

- Pharmacological management of chronic neuropathic pain – Consensus statement and guidelines from the Canadian Pain Society: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4273712/

Chronic Non-Cancer Pain

- 2017 Canadian Guideline for Safe Opioid Use in Chronic Non-Cancer Pain: http://nationalpaincentre.mcmaster.ca/guidelines.html
- Opioid Management: https://ocfp.on.ca/tools/opioid-management

Chronic End-Of-Life/Malignant Pain

- Symptom Management Guides: https://smg.cancercare.on.ca/#intervention227
- Pain in Adults with Cancer: Screening and Assessment (Cancer Care Ontario) https://archive.cancercare.on.ca/common/pages/UserFile.aspx?fileId=350823
- WHO's cancer pain ladder for adults: http://www.who.int/cancer/palliative/painladder/en/

- **Non-Pharmacological Interventions**[8]

Non-pharmacological (physical and psychological) interventions should be considered along with pharmacological interventions to reduce pain, improve sleep, mood and general well-being.

- Psychological interventions related to education have been shown to assist with coping and enhancing the person's ability to self-manage to lessen pain.
- The evidence varies on the effectiveness of the following physical and psychological non-pharmacological interventions when they are used alone or in combination with pharmacological interventions:
    - Psychological interventions;
    - Cognitive behavioural therapy; and
    - Massage, relaxation, exercise, energy flow and education in older adult.
- Non-pharmacological interventions should only be used based on the supporting evidence for the person's population group (e.g., age, pain characteristics and health condition).

- **Pain Management Education**[9]

Pain management education may help effective adoption and use of pain management strategies by the person and their family and caregivers. Education should include but not be limited to:

- Information on pharmacological, physical and psychological pain management options, emphasizing both risks and benefits; and
- Awareness that health care professionals do not perceive reports of pain as complaining.

In special populations (e.g., persons unable to self-report), nurses and other health professionals must inform families/caregivers about:

- Their role in implementing pain management interventions;
- Behavioural observations that indicate the presence of pain in persons unable to self-report; and

- Strategies to monitor and reassess the effectiveness of the interventions.

It is important to ensure that persons and their families/caregivers understand the difference between drug addiction.

- **Monitoring and Evaluation of Pain Management Interventions**[10]

Ongoing monitoring and evaluation of a person's response to pain management interventions is necessary to adjust the strategies and ensure effective pain control and minimization of adverse effects.

- A person's response to pharmacological, physical and psychological interventions can vary over time.
- It is important to consistently use the same tool each time to get accurate reassessments on the presence and intensity of pain.
- The frequency of reassessments will be determined by:
  - Presence of pain;
  - Pain intensity;
  - Stability of the person's medical condition;
  - Type of pain e.g. acute versus persistent; and
  - Practice setting.

- **Additional Information & Resources**

For additional up-to-date information on the use of non-pharmacological interventions for pain management, refer to the National Centre for Complementary and Alternative Medicine (NCCAM), available at http://nccam.nih.gov/.

For more information and resources on pain assessment and management, refer to Appendix D (p. 76) and Appendices K-M (PP. 92-95) in the Guideline, *Assessment and Management of Pain, Third Edition*.

References

1. International Council of Nurses. About ICNP®. Retrieved from http://www.icn.ch/what-we-do/about-icnpr/
2. Registered Nurses' Association of Ontario. Assessment and Management of Pain (3rd ed.), Practice Recommendation 1.1. Toronto, ON: Author. Retrieved from https://rnao.ca/sites/rnao-ca/files/AssessAndManagementOfPain_15_WEB-_FINAL_DEC_2.pdf
3. Ibid, Practice Recommendation 1.3.
4. Ibid, Practice Recommendation 1.2.
5. Ibid, Practice Recommendation 1.4.
6. Ibid, Practice Recommendation 2.2.
7. Ibid, Practice Recommendation 3.1.
8. Ibid, Practice Recommendation 3.2.
9. Ibid, Practice Recommendation 3.3.
10. Ibid, Practice Recommendation 4.1.