Pain Assessment

Introduction

Nurses have an ethical responsibility to manage pain and the suffering derived from it (Miller, 2024). To assess pain adequately and accurately, a multidisciplinary and 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 is 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 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 commonly used include:
    - Visual Analog Scale (VAS)
        - horizontal line with verbal description at each end
        - patient marks the point on the line that best describes their severity.
    - Numeric Rating Scale (NRS)
        - zero to ten scale (0 = no pain; 10 = worst pain imaginable)
        - patient indicates number that best correlates to their pain.
    - 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, increased oxygen requirement, abnormal vital signs (increased heart rate, respiratory rate or blood pressure), 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

Dydyk A.M., Grandhe S. Pain Assessment. (2023, January 29). Pain assessment. *StatPearls*. https://www.ncbi.nlm.nih.gov/books/NBK556098/

Miller, P. H. (2024). Moral distress and pain management: Implications for critical care nurses. *Critical Care Nursing Clinics of North America, 36*(4), 567–574. https://doi.org/10.1016/j.cnc.2024.04.011

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