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# Pain Assessment

**Orly Liberman R.N. M.A**  
**Recanati School for Community Health Professions,**  
**Ben Gurion University of the Negev**  
**Israel**

Orly Liberman, February 2008


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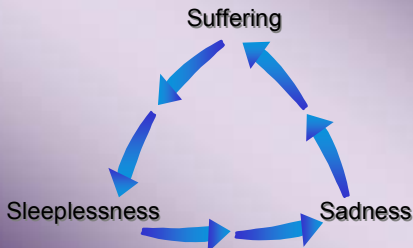
-  Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage. (IASP,1998)
-  It is the most common reason of seeking health care and is related to many disorders, diagnostic tests and treatments.
-  Pain alters the quality of life more than any other Health related problem.

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## The Terrible Triad of Chronic Pain



```
graph TD; Suffering --> Sadness; Sadness --> Sleeplessness; Sleeplessness --> Suffering;
```

(National Institute of Neurological Disorders and Stroke 1989)

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❏ “When we can assess the patient’s pain accurately, we can treat it more effectively”  
McCaffery, 1983

❏ “Pain is whatever the experiencing person says it is, existing whenever the person says it does”  
McCaffery, 1989

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### The Complexity of Chronic Pain: Biopsychosocial Paradigm

Pathophysiological changes  
Psychological functioning  
Social factors  
Cultural factors

Patient's perception of and response to distress (pain)

Diversity in presentation of chronic pain symptoms (eg, severity, duration, degree of functional disability)

(Weisberg MB. *Postgrad Med*. 1999)  
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❖ Pain is a subjective, multi-dimensional experience, influenced by many factors in addition to the physiological component.

Pain assessment includes:

- Psycho-social factors.
- Previous experience.
- Cultural and environmental influences.
- Emotional states such as depression.

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## The Purpose of Pain Assessment

- Determining its nature, severity and degree.
- Helping in the diagnosis.
- Helping choose treatment methods.
- Evaluating the efficiency of the treatment strategies.

Melzack R., Katz J. 1994


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- Assessing pain involves the patient, the nurse and the physician, and it should be performed:  
Whenever pain is reported  
At appropriate intervals after pharmacological or other interventions.
- In adults:  
The most accurate pain assessment is based on the patient's own report.  
The patient's report is true and real.

**Believe the patient even if the reason for the pain is unknown or unclear.**

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## Preliminary Assessment

The purpose of preliminary assessment is to evaluate pain by:

**Location Severity Duration Frequency Type Cause/origin**

- Later, the assessment should include:
- Detailed medical history and physical examination.
- Evaluating psychosocial and other factors influencing the patient's reaction to pain.
- Evaluating the impact of pain on daily functions such as sleeping, walking, working, etc.
- Evaluating factors that reduce or increase the pain.

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 **Remember! There is no objective measure of pain**

The type of questions we ask the patient is important


**Features of the pain assessment tool:**

-  Easy to implement in clinical and research settings.
-  Provides immediate and comprehensive information about pain.
-  Easy to calculate.
-  Sensitive to the smallest changes.
-  The tool is chosen by the staff according to the clinical condition and the type of pain.

Schofield P. 1995

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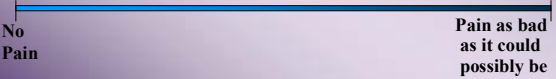
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 **Examples of Pain Severity Assessment Tools**

**VAS-Visual Analogue Scale**


A ruler composed of a 10 cm line

At each end are the definitions “no pain” and “pain as bad as it could possibly be”



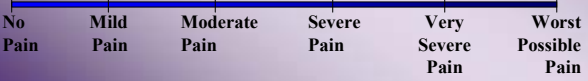
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 **Verbal Graphic Rating Scale**

A ruler with a verbal description of pain severity:

At one end – no pain.  
At the other end – worst possible pain.  
Between them a scale of mild, moderate, severe and very severe pain.



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**Numerical Graphic Rating Scale**

A ruler rating pain severity from 0 meaning no pain to 10 meaning worst possible pain.

0 1 2 3 4 5 6 7 8 9 10  
No Pain Moderate Pain Worst Possible Pain

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**W.H.O**

The World Health Organization divides the pain scale into 3 steps and establishes the recommended pharmacological treatment protocols.

- 0-4 slight pain
- 5-7 moderate pain
- 8-10 severe and unbearable pain

**Stepped Approach to Pain Management**

Step 3  
Step 2  
Step 1  
Increasing Pain

Adapted from WHO 1996 Orly Liberman, February 2008 14

The most popular ruler combines descriptions of pain severity through verbal and numerical descriptions, color changes and facial expressions.

The tools' main disadvantage:  
They only refer to pain severity and not to other aspects of pain.

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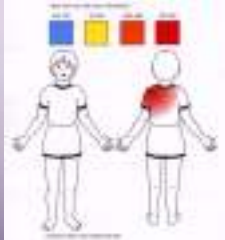
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**Assessing pain location:**

**Body diagram**

The patient is requested to mark on the diagram the exact location or area of pain (popular mainly among children).



Buchwell, A. 1997

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**Assessing other pain characteristics**

The patient is questioned using words describing:

**Pain type**  
pressing tearing piercing burning vague

**Pain duration**  
seconds minutes hours days

**Pain frequency**  
continuous intermittent

The patient is questioned on other issues:  
Factors easing or worsening the pain;  
The impact of pain on general daily functioning, walking, sleeping, normal work, interpersonal relations, enjoying life.

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**Effects of Chronic Pain on Quality of Life**

Healthcare professionals must assess how pain impacts a patient's life and what the patient's life was like before the pain

Identify how pain affects your patient's:

- Sleep
- Household chores
- Mood
- Work tasks
- Leisure interests

(Schneider JP. *J Care Manage*, 1998) (Marcus DA. *Am Fam Phys*, 2000)

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Additional tools recommended mainly for assessing chronic pain and mainly for research:

### McGill Pain Questionnaire- MPQ

- Focuses on assessing pain quality
- Composed of word groups describing and classifying pain into several categories:  
sensory    emotional    evaluative    other

Melzack R , Katz J 1975

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### Combined tools

Combining pain severity rules, pain location diagrams and other pain characteristics.

#### Initial Pain Assessment Tool

Adapted from  
McCaffery M,  
Beebe. Pain:  
Clinical Manual  
For Nursing  
Practice. St.  
Louis Mo: CV  
Mosby Co; 1989

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### Assessing pain in the elderly

- Based on the patient's report even if there is cognitive deterioration
- The elderly tend to report exhaustion and discomfort more than pain.
- The elderly are afraid to report pain due to fear of diagnostic tests and treatments with side effects.
- When assessing pain in elderly patients with language difficulties or serious cognitive problems, non-verbal expressions of pain should be noted: crying, complaints, changes in activity, behavioral decline.
- With elderly patients with language difficulties or cognitive problems, pain assessment is based on the report of their main care givers.

AGS 1998

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### Assessing pain in children and adolescents

- In assessing pain in children, two phenomena should be noted:
  - The pain itself
  - The fear of pain
- Pain assessment in children uses a multi-disciplinary approach with four components:
  - Self-reporting of pain
  - The child's behavior during pain
  - Medical physiological indices
  - The child's level of cognitive development

Thompson & Varni 1986

**The assessment combines methods and approaches according to the child's level of cognitive development**

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### Assessment based on self-reporting is effective in children capable of talking and communicating

**Examples of tools:**

- Age 3+: **Faces Pain Rating Scale**  
Wong & Baker 1995
- Age 4+: **Word Graphic Rating Scale**  
Tesler et al 1991
- Color Tool**  
Eland 1993
- Poker Chip Tool**  
Hester 1979, 1989
- Age 5+: **VAS – verbal and numerical**

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### Assessment based on the child's behavior during pain

Conducted by the staff observing the child, for children unable to speak such as: babies, children on ventilators, very sick children.

**Use of tools:**

- Assessing crying – groaning, whining, screaming.
- Facial expressions – screwing up eyes, strained mouth.
- Motor reactions.

Johnson et al 1990  
Grunau & Craig 1987

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 **Pain assessment based on medical physiological indices**

Changes in blood pressure, pulse and breathing are not unique to pain, and these indices return to the norm after a while, even if the pain continues.

Ross & Ross 1988


**The disadvantage of behavioral and physiological tools – lack of specificity.**

There are multi-disciplinary tools based on observing the baby's behavior combined with objective physiological indices.

**Pain Observation Scale for Young Children - Pocs**

Composed of 7 behavioral and physiological categories.


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 **Parental involvement in pain assessment**


Parents are the first to decipher the child's pain reactions and behavior, and can distinguish between the child's pain and another experience.

**Remember, each child has an individual way of experiencing pain. The tool and method most appropriate for each child should be found.**


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 **Documenting the assessment**

-  Treat pain as the fifth vital sign.
-  Pain severity is recorded in the vital sign sheet.
-  Documenting is essential for determining appropriate treatment and for follow-up and monitoring of pain treatment.



Pain severity according to the patient



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### Conclusions – Guidelines in Pain Assessment

- Remember that failing to assess pain is a critical factor that could lead to under-treatment.
- Choose a pain assessment strategy and tools suitable to the clinical field.
- Ensure that the staff accepts and is trained to use the chosen tools.
- Base the assessment as much as possible on the patient's report.
- Ensure the patient understands what is expected of him/her.
- Use the family and main care givers when it is not possible to rely on the patient's report.
- Manage the pain treatment according to the assessment.

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Pain assessment ➡ Appropriate treatment ➡ Pain reduction

Thank you  
for listening



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