Effective Use of Pain Assessment Tools

SCREEN: Ask are you experiencing any discomfort right now?
   If No: document “zero” pain and reassess periodically
   If Yes: ask about its nature (verbal description) pattern (over time) and location

Show & describe the pain tools to the patient to determine which one is easiest and most meaningful.

Starting with the NUMERIC PAIN SCALE:
   - It is important to recognize this is an 11-point scale (0-10 not 1-10).
   - Have the patient point to or say the number representing pain intensity “right now” between:
     o 0 = no discomfort
     o 10 = or the worst they or anybody else could possibly experience
     o Showing the patient a printed version of the scale improves comprehension and accurate use.
     o “On a scale of 0 to 10; how much pain (or discomfort) are you experiencing now?”

If that is not easy and meaningful use the SIMPLE DESCRIPTIVE SCALE
   - Determine if discomfort is “None” (chart 0) or the worst possible (chart 10)
   - Ask if the discomfort or pain is mild, moderate severe, or extreme
     o Record 2 (for mild), 4 (for moderate), 6 (for severe), or 8 (for extreme) accordingly
     o If the patient reports its between 2 words select the odd number between then
       ▪ (e.g. the score of a report of pain between mild and moderate =3)

If that is not easy and meaningful use the FUNCTIONAL PAIN SCALE
   - Determine if discomfort is “None” (chart 0) = 0
   - Determine if it is tolerable (“<5”) or intolerable (“≥5”)
     o Tolerable pain that does not interfere with activities = 2
     o Tolerable pain that interferes with physically demanding activities = 4
     o Intolerable pain that interferes with physically demanding activities = 5
     o Intolerable pain that interferes with active but not passive activities = 6
     o Intolerable pain that interferes with passive activities (e.g. reading) = 8
     o Pain so severe the patient can’t do any active or passive activities …. (can’t even converse about pain without writhing / screaming) = 10

FACES PAIN SCALE (Pediatric or Critical Care Units)
   ✓ Show the Faces Pain Scale to the patient (this is a self-report scale for communicative patients)
   ✓ Say, "These faces show how much something can hurt. This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to right-most face] – it shows very much pain. Point to the face that shows how much you hurt [right now]."
   ✓ Score the chosen face 0, 2, 4, 6, 8, or 10, counting far left (“0) to far right (“10).

If the patient is unable to self report pain use a BEHAVIORAL PAIN SCALEs
   - Checklist of Nonverbal Pain Indicators is first line for adults (total rest & movement scores)
     o Observe the patient at rest for universal signs of pain, record how many are seen
       ▪ Vocal/verbal sounds; facial expressions; bracing; restlessness; &/or rubbing
     o Observe patient next with movement for the same signs pain, record how many are seen
   - Use the PAINAD scale in dementia patients, Rate the 5 universal pain behaviors listed
   - Critical Care Pain Observation Tool is used on critical care patients unable to self-report
   - In PACU or Neuro Intensive Care Init the Adult Nonverbal Pain Scale is preferred.

For chemically paralyzed patients with painful conditions/procedures, use Assume Pain is Present