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 and pattern/location

Try the NUMERIC PAIN SCALE:
   - It is important to recognize this is an 11-point scale (0-10 not 1-10).
   - Ask the patient if they would recognize:
     o if the discomfort were completely gone (“rating of 0”)
     o and the worst they or anybody else could possibly experience (“10”)
   - Have the patient rate the intensity of their pain/discomfort “right now” verbally with a number or by pointing to the number that represents their pain intensity
   - Once the patient understands this scale, follow-up question can inquire about pain without the visual aide
     o (“on a scale of 0 to 10; how much pain are you experiencing now?”)

If that is not easy and meaningful use the VERBAL DESCRIPTOR 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, 4, 6, or 8 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

If the patient is unable to self report pain use a BEHAVIORAL PAIN SCALE
   - The modified Checklist of Nonverbal Pain Indicators is first line for adults
     o Observe the patient at rest for universal signs of pain, record how many are seen
       - Vocalizations, facial expressions, bracing, restlessness, rubbing
     o Observe the patient with movement for the same signs pain, record how many are seen
   - With Dementia, use the PAINAD scale
   - With a critical care patient use the Critical Care Pain Observation Tool
   - 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