Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg	CLINICAL PRACTICE GUIDELINE		
TITLE PAIN ASSESSMENT AND MANAGEMENT June 1st, 2008			CODE
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INTRODUCTION

The Winnipeg Regional Health Authority's (WRHA) Mission is to protect and improve the health and well-being of citizens who utilize health care services within the City of Winnipeg. The WRHA is committed in providing evidence-based practice that promotes safe care and prevents harm to patients. The Pain Assessment and Management Clinical Practice Guideline (CPG) is a tool that has been developed by regional pain experts and provides specific evidence-based information to assist health care providers in conducting a high quality pain assessment that will lead to effective pain management.

SCOPE

This clinical practice guideline is intended to guide assessment and management of pain within the WRHA Personal Care Home Program, WRHA Family Medicine Program, WRHA Palliative Care Program, CancerCare Manitoba, and other sites/programs as applicable.

GOALS

- To provide regional guidelines for pain assessment and management based on current evidence and expert opinion.
- To ensure pain assessment and management is prompt, appropriate and consistent.
- To ensure pain assessment includes the use of systematic and validated tool(s).
- To promote continual monitoring and improvement in outcomes of patient outcomes in pain management.
- To provide the foundation upon which health care provider education should be based.

GUIDING PRINCIPLES

- Effective pain assessment and management requires coordinated interdisciplinary intervention in collaboration with persons and their families.
- Persons have the right to appropriate assessment and management of pain.
- Unrelieved pain has consequences and should be prevented where possible.
- Unrelieved pain requires urgent treatment.
- Pain is a subjective, multidimensional and highly variable experience for everyone, and requires a critical analysis of pain-related factors and interventions.
- A multi-modal treatment approach is recommended. This approach can combine more than one type of treatment modality. This may result in lower doses of

medication, decreased incidence of side effects, and facilitate treatment of pain in persons who do not respond to a single agent. This can include pharmacological and non-pharmacological approaches.

- Health care providers are professionally and ethically obligated to advocate for change in the treatment plan when pain relief is inadequate.
- Ongoing education is essential to maintain clinical competency in pain assessment and management.
- Health care providers must advocate for policy change and resource allocation that support effective pain management.

GLOSSARY OF TERMS

Acute Pain – the normal, predictable, appropriate response to a noxious stimulus or disease process that threatens or produces tissue injury, and that abates following remission of the stimulus or healing of the injury

Adjuvant Analgesics – any medication with a primary indication other than pain but with analgesic properties in some painful conditions.

Adverse Consequences – refers to an unpleasant symptom or event that is due to or associated with a medication such as impairment or decline in the individual's mental or physical condition or functional or psychosocial status.

Breakthrough Pain - a transitory flare of pain of moderate to severe intensity occurring on a background of otherwise controlled pain

"**Ceiling Effect**" - the property of increasing doses of a given medication to have progressively smaller incremental effect

Chronic Pain – pain associated with a chronic disorder, or pain that persists beyond resolution of an underlying disorder or healing of an injury, and that is often more intense than the underlying process would predict

Complementary/ Alternative Therapy – non-pharmacological strategies to relieve pain (may include such techniques as superficial heat and cold, massage, relaxation, imagery, pressure or vibration, therapeutic communication)

Physical Dependence- a chemical phenomenon created by receptors in the brain whereby persons who no longer need an opioid after long-term use need to reduce their dose slowly over a prolonged time period to prevent withdrawal symptoms

Incident Pain - pain which comes on as a result of an action or activity (such as planned turns, transfers/ ambulation, bathing, changing clothes, dressing changes, disimpaction)

Neuropathic Pain - pain initiated or caused by a primary lesion or dysfunction in the nervous system

Nociceptive Pain - arises from stimulation of pain receptors within tissue, which has been damaged or involved in an inflammatory process

Opioids – class of drugs originally derived from the opium poppy that are generally prescribed to manage pain

Opioid Toxicity – symptoms of toxicity include hallucinations (often visual or tactile), cognitive impairment, delirium, hyperalgesia, allodynia, sedation, and myoclonus (characterized by "muscle jerking" that can be localized or generalized). If very severe, these can go on to become generalized seizures. Patients with renal impairment and patients on high doses of opioids for long periods of time appear to be at a higher risk.

Pseudoaddiction– is a term that describes patient's behaviors that may occur when pain is under treated. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch" and may otherwise seem inappropriately "drug seeking". Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

Aberrant Dependence (AKA psychological dependence or an Addiction)- displaying aberrant use of medication, causes can include: pseudoaddiction, addiction, diversion, inadequate understanding or instruction or chemical coping.

Tolerance - a pharmacological principle that patients need increasing doses of pain medication to accomplish the same level of comfort; thought to be due to changes in opioid receptors

EVIDENCE

This document is based on a compilation of published Clinical Pain Guidelines on pain assessment and management as well as review and feedback from local expert opinion. This Clinical Pain Guideline should be perceived as reflecting the current state of knowledge in the field of pain assessment and management.

Best practice demands that health care providers be guided by best available evidence. The grading system used in this guideline has been adapted from the Canadian and U.S. Preventive Task Force Review. Levels of evidence are graded on strength of the scientific evidence. For the purpose of CPG development data was classified as:

Class I evidence:	Prospective randomized controlled trials (PRCTs) - the gold standard of clinical trials.
Class II evidence:	Clinical studies in which data were collected prospectively and retrospectively analysis, which were based on clearly reliable data. These types of studies include observational studies, cohort studies, prevalence studies and case control studies

Class III evidence: Most studies based on retrospective collected data. Examples include clinical series, databases or registries; care reviews, case reports and expert opinion. Examples include: observational studies, cohort studies, prevalence studies and case controlled studies.

In order to understand the strength of the evidence, each recommendation has been cited with a level of recommendation, as follows:

Level 1 This recommendation is convincingly justifiable on the available scientific information alone. It is usually based on Class 1 data; however strong Class II data evidence may form the basis for level 1 recommendation, especially if the issue does not lend itself to testing in a randomized format.

Level 2 This recommendation is reasonably justifiable by scientific evidence and strongly supported by expert opinion. It is usually supported by Class II data or a preponderance of Class III evidence.

Level 3 This recommendation is supported by available data but adequate scientific evidence is lacking. It is generally supported by Class III data. This type of recommendation is useful for educational purposes and in guiding future studies.

RECOMMENDATIONS

PART A – PAIN ASSESSMENT

Recommendation 1:
Routinely screen all persons for pain by asking the person about the presence of pain. Pain terminology typically used by the person to describe the pain such as the use of the word “ache”, “hurt” and/or “discomfort” should be assessed and the term used in the ongoing assessment. Screening should occur at first contact and be repeated as indicated depending on the person’s condition, setting, care goals, etc.

- For children unable to verbalize presence of pain, screen for pain using one of the following tools (refer to Appendix A):
    - The Faces, Legs, Activity, Cry and Consolability Pain Assessment Tool (the FLACC)
    - Non-communicating Children’s Pain Checklist – Revised (NCCPC-R)
    - Non-communicating Children’s Pain Checklist – Post Op Version (NCCPC-PV)

- For the person with communication difficulties/impairment, attempt to facilitate communication where possible.

- For adults unable to verbalize the presence of pain, screen for pain using one of the following tools (refer to Appendix B):

- Checklist of Nonverbal Pain Indicators (CNPI)
- The Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN)
- Or equivalent tool(s).

Level of Recommendation = 1

Recommendation 2:
Use self-report as the primary source of assessment. Family and healthcare provider reports of pain are included for children and adults unable to give self-report. Pain assessment should also include assessment of behavioural indicators of pain.
Level of Recommendation = 1

Recommendation 3:
Select a systematic pain assessment tool(s) (refer to Appendix C) to assess the parameters of pain, which include:

- Location and radiation;
- Onset, duration and timing;
- Precipitating factors;
- Alleviating factors, including medication and non-pharmacological therapies;
- Person's description of pain; and
- Intensity and acceptable level of intensity (refer to Appendix D for recommended pain intensity rating tools)

Level of Recommendation = 2

Recommendation 4:
Choose a pain intensity rating tool based on the person's preferences, age, cognitive function and language. The same tool should be used each time pain is assessed and during the same level of activity.
Level of Recommendation = 3

Recommendation 5:
The following parameters are part of a comprehensive pain assessment:

- Effects on function, activities of daily living, sleep, mood and cognition;
- Physiological and behavioural indicators of pain;
- Effects and understanding of current illness;
- All past and current treatments for pain, their effectiveness, and their side-effects;
- Displaying aberrant use of medication;
- Meaning of pain and distress caused by the pain;
- Coping responses to stress and pain;
- Psychological, social, and spiritual aspects;
- Situational factors – culture, language, ethnic factors, economic aspects of pain and treatment;
- Person's preferences and expectations/beliefs/hopes/myths about pain management methods; and
- Person's preferences and response to receiving information related to his/her condition and pain.

Level of Recommendation = 3

Recommendation 6:
Identify the most likely cause(s) of the person's pain. The appropriate scope of an assessment depends on the person's care goals. The following parameters should be considered:

- Existing and past medical diagnoses and conditions;
- Current and previous medications;
- Physical examination; and
- Relevant laboratory and diagnostic tests.

Level of Recommendation = 2

Recommendation 7:
Reassess pain on a regular basis according to the type and intensity of pain and the treatment plan.

- Pain is reassessed at each new report of pain, any change in the presentation of pain, and when pain is not relieved by previously effective strategies.
- Pain is reassessed after the intervention has reached peak effect.
- Acute post-operative pain should be regularly assessed as determined by the operation and severity of pain, with each new report of pain or instance of unexpected pain, and after each analgesic, according to peak effect time.

Level of Recommendation = 2

Recommendation 8:
Include the following parameters in the regular re-assessment of pain:

- Current pain intensity, quality and location;
- Intensity of pain at its worst in past 24 hours, at rest and on movement;
- Extent of pain relief achieved – response (reduction on pain intensity scale);
- Effects of pain on activities of daily living (ADL), sleep, mood and cognition;
- Side effects of medications for pain treatment (nausea, constipation);
- Displaying aberrant behaviors;
- Evidence of Adverse consequences such as a decline in the patient's overall mental or physical condition and/or functional and psychosocial status;
- Strategies used to relieve pain, for example:
  - Analgesic doses taken regularly for breakthrough pain
  - Non-pharmacological interventions:
    - Physical modalities
    - Cognitive/behavioural/psychosocial strategies
    - Rehabilitative strategies
    - Complementary/alternative therapy
    - Environmental changes.

Level of Recommendation = 2

Recommendation 9:
Immediately assess unexpected intense pain, particularly if sudden, associated with altered vital signs (e.g. hypotension, tachycardia, fever, dyspnea) or associated with changes in function, mobility, and/or behavior.
Level of Recommendation = 2

Recommendation 10:
Document pain assessment regularly and routinely on standardized forms that are accessible to all clinicians involved in care (refer to Appendix C).
Level of Recommendation = 3

Recommendation 11:
Advocate on behalf of the person for changes to the treatment plan if pain is not being relieved and/or support the person to advocate on their own behalf.
Level of Recommendation = 2

PART B – PAIN MANAGEMENT

Establish a Plan

Recommendation 12:
Establish a plan for pain management in collaboration with interdisciplinary team members that is consistent with individual and family goals for pain relief, comfort and function, taking into consideration the following factors:

- Assessment findings;
- Baseline characteristics of pain;
- Physical, psychological, sociocultural and spiritual factors shaping the experience of pain;
- Etiology;
- Most effective pharmacological and non-pharmacological interventions;
- Management interventions; and
- Current and future primary treatment plans.

Level of Recommendation = 2

Recommendation 13:
Treat the underlying cause of the pain, whenever possible. However, pain management can begin before the source of pain is identified.
Level of Recommendation = 2

Select Appropriate Analgesic

Recommendation 14:
Use the World Health Organization (WHO) Analgesic Ladder (Appendix E) to select the appropriate analgesic. Select the analgesic based on the highest likelihood of gaining pain relief with the lowest likelihood of side effects. Ensure that the selection of analgesics is individualized to the person, taking into account:

- The type of pain (acute and/or chronic, nociceptive and/or neuropathic)
- Intensity of pain
- Allergies
- Potential for analgesic toxicity (age, renal or hepatic impairment, peptic ulcer disease thrombocytopenia and implication for non-steroidal, anti-inflammatory drugs-NSAIDs)
- General condition of the person
- Concurrent medical conditions
- Other medications

- Response to prior or present medications
- Financial cost
- Person's preferences
- Route of administration; and
- Feasibility of use within setting of care.

Level of Recommendation = 2

Recommendation 15:

Recommendations regarding transdermal fentanyl:

- Should not be used in opioid naïve patients (as per the Duragesic drug monograph), patients should be on the equivalent of 60 mg of morphine per day before changing to the transdermal patch.
- Should be reserved for chronic, stable pain. In view of its long duration of action and lag between dose adjustment and observed effect, it should not be used for titration of analgesia in unstable pain circumstances.
- Dose adjustments should generally not be made more than twice/week.
- Elevated temperature, either with fever or local application of heat such as a heating pad or hot water bottle, can result in fatal fentanyl overdose due to increased absorption. Caution must be exercised in such situations.

Level of Recommendation = 2

Recommendation 16

Avoid using meperidine (this drug has been taken off the formulary in most WRHA sites):

- Meperidine is contraindicated in patients with impaired renal function, the elderly, neonates, and infants less than 6 months of age.
- Meperidine is contraindicated for the treatment of chronic pain and in palliative patients due to the build-up of the toxic metabolite normeperidine, which can cause fatal neurotoxicity with seizures.
- Meperidine has a limited role in acute pain and no role in chronic pain.

Level of Recommendation = 2

Recommendation 17:

Consider the addition of other medications in the management plan. Using agents in combination offers advantages including:

- Lower doses of some agents, thus reducing the risk of side effects.
- Inhibition of nociceptive processing at multiple (i.e. peripheral and central) levels, thus enhancing analgesia.
- Treatment of pain in patients who do not respond to a single agent.

Level of Recommendation = 2

Determine Dosage & Frequency

Recommendation 18:
Use principles of dose titration (start low, go slow) specific to the type of pain to reach the analgesic dose that relieves pain with a minimum of side effects, according to:

- Cause of the pain
- Person's response to therapy
- Clinical condition
- Concomitant drug use
- Weight
- Age
- Person characteristics (lifestyle and patterns of daily living) of the individual
- Known pharmacokinetics and pharmacodynamics of the drugs, such as onset and peak effect; and duration of the analgesic effect.
- Doses may be increased every 24 hours for persons on immediate release preparations, and every 48 hours for persons on controlled release opioids. Transdermal fentanyl may be adjusted every 3 days, however dose titration in the elderly must be undertaken with caution due to potential for drug accumulation.
- Non-opioids have a ceiling effect and may cause significant toxicity at high doses
- Most opioids do not have an analgesic ceiling (exceptions include meperidine, codeine).
- The opioid dosage can be titrated upwards until pain relief occurs or limiting side effects develop

Level of Recommendation = 2

Recommendation 19:
Use the following parameters when starting a patient on opioids:

- Use an immediate-release preparation.
- Use regular and/or as needed (PRN) medication dosage as indicated.
- Administer around-the-clock medications after an optimal dose over a 24-hour interval is determined.
- If severe pain is expected for 48 hours post-operatively, routine administration may be needed for that period of time. Late in the post-operative course, analgesics may be effective given on a PRN basis.
- After establishing the amount needed daily to control the patient's pain, convert the daily dose to a sustained-release preparation that is given every 8 to 24 hours based on formulation.
- In chronic pain, opioids are administered on an around-the-clock basis, according to their duration of action.
- With severe pain situations it may be warranted to start a regular intermittent and continuous parenteral infusion in order to maintain constant serum blood levels to produce a sustained analgesia effect.

Level of Recommendation = 2

Recommendation 20:
Promptly treat pain that is not optimally controlled on regular scheduled doses of analgesic referred to as breakthrough pain (end-of-dose failure, incident or spontaneous pain) using the following principles:

- Breakthrough doses of analgesic in the post-operative situation are dependent on the routine dose of analgesic and may be administered as bolus medications
- Breakthrough doses of intervals of analgesic should be determined by anticipating the peak and duration response of the drug when given by that specific route: Approximately 5-10 minutes for intravenous, 30-60 minutes for subcutaneous injection, and 1-2 hours for oral administration. Nasal or sublingual doses of fentanyl and sufentanil tend to peak within 15 minutes.
- It is most effective to use the same opioid for breakthrough pain as that being given for around-the-clock dosing
- Individuals with chronic pain should have:
  - An immediate release opioid available for pain (breakthrough pain) that occurs between the regular administration times of the around-the-clock medication.
  - Breakthrough doses of analgesic for continuous pain should be calculated as 10 – 15 per cent of the total 24-hour dose of the routine around-the-clock analgesic.
  - Breakthrough analgesic doses should be adjusted when the regular around-the-clock medication is changed.
  - Adjustment to the around-the-clock dose is necessary if more than 2-3 doses of breakthrough analgesic are required in a 24-hour period, and pain is not controlled.

Level of Recommendation = 2

Recommendation 21:
Anticipate incident pain and combine pharmacological and non-pharmacological options for prevention. Examples of incident pain include procedures such as pain with movement, medical tests and dressing changes, routine care, and treatments such as physiotherapy.
Level of Recommendation = 2

Establish Route

Recommendation 22:
Recognize that no single route of drug administration is appropriate for all clinical situations. Advocate for the use of the least invasive route of administration of pain management modalities. Tailor the route to the individual pain situation and preference, efficacy and the care setting.

- Oral route is the preferred route. It is convenient, flexible and associated with stable drug levels. A feeding tube is considered an oral route.
- Sublingual route provides a rapid onset and is an effective alternative when there are swallowing difficulties.
- Transdermal route is a non-invasive alternative means of continuous drug delivery especially if the oral route is inappropriate. The Fentanyl Patch is primarily for chronic pain in patients who are already taking opioids.
- Rectal route, if appropriate, is effective, but consideration must be given to personal dignity and comfort.
- Subcutaneous (intermittent or continuous) is convenient and equally effective as the intravenous route.
- Intravenous (intermittent or continuous) route provides a rapid onset of pain relief. It provides a stable effect that can attain steady blood concentration levels.

However, in patients with compromised veins, this route may be difficult to maintain.
- Epidural analgesia and peripheral nerve block must be managed according to institutional policy.
- Intramuscular route is not recommended as it has multiple disadvantages (e.g. pain, erratic absorption, fluctuating drug levels, tissue fibrosis). Its use should be discouraged in pediatrics, palliative or end of life care (there may be situations, especially in the home setting, where IM dosing is used in acute crisis situations)

Level of Recommendation = 3

Anticipate and Manage Side Effects

Recommendation 23:
Anticipate and monitor individuals taking opioids for side effects. Treat side effects promptly. Expected side effects could include:

- Constipation
  - Patients starting opioid treatment should be placed on bowel regimens concurrently to avoid constipation.
- Nausea and vomiting (usually presents for 1-5 days and then stops)
- Pruritis
- Mild sedation or fatigue for the first 72 hours
- Mild hypotension

The following side effects are more severe and require immediate attention by the healthcare team:

- Fatigue that persists beyond 72 hours
- Disorientation and/ or hallucinations
- Altered level of consciousness
- Respiratory depression
- Symptomatic hypotension

Level of Recommendation = 3

Recommendation 24:
Use the following strategies to managing side effects:

- Add a drug that counteracts the effect (e.g. laxatives for constipation or antihistamine for pruritis),
- Change the dosage or route of administration (i.e., metabolities attain higher concentrations with oral therapy and a switch to parenteral may decrease side effects),
- Try a different drug within the same class,
- Try combination therapy to alleviate side effects. For example, adding a non-opioid or adjuvant analgesic to an opioid regimen may allow use of a lower dose of the opioid.

Level of Recommendation = 3

Recommendation 25:
Monitor persons for signs and symptoms of drug toxicity. Persons at high risk for toxicity include those who may have difficulties metabolizing opioid analgesic

medications and may include: children, the elderly, persons at end of life, and persons with renal or hepatic impairment. Recommend a change in opioid analgesic using an equianalgesic table to ensure equivalency. Recognize that the safest method is to reduce the dose of the new analgesic by one-half in a stable pain situation due to incomplete cross-tolerance. However, equianalgesic dose ration tables are not 100% precise and reducing the dose of the new analgesic by one-half could potentially de-stabilize the patient's pain control. In complex pain situations consult a pain specialist before changing an opioid.
Level of Recommendation = 3

Consider Non-Pharmacological (Complementary/ Alternative) Management

Recommendation 26:
Combine pharmacological methods with non-pharmacological methods to achieve effective pain management.

- Non-pharmacological methods of treatment should not be used to substitute for adequate pharmacological management.
- The selection of non-pharmacological methods of treatment should be based on individual preference and the goal of treatment.
- Any potential contraindications to non-pharmacological methods should be considered prior to the application.
- Institute specific complementary strategies known to be effective for specific types of pain

Level of Recommendation = 3

Refer to Experts

Recommendation 27:
Refer persons whose pain is not relieved after following standard principles of pain management to a specialist(s) skilled in dealing with the particular type of pain and population.
Level of Recommendation = 2

Educate Person and Family

Recommendation 28:
Provide the person and their family/care providers with information about their pain and the measures used to treat it, with particular attention focused on correction of myths and strategies for the prevention and treatment of side effects.

- Ensure that individuals understand the importance of promptly reporting unrelieved pain, changes in their pain, new sources or types of pain and side effects
- Consider providing persons and families/ care providers with a written copy of the treatment plan, and all revisions, to promote their decision-making and active involvement in the management of pain.
- Clarify the differences between substance abuse, dependence, addiction, tolerance, and physical dependence to alleviate disbeliefs that can prevent optimal use of pharmacological methods for pain management.

- Teach and encourage persons and families to document pain assessment and the effect of analgesics on the appropriate tools (Appendix F)
  Level of Recommendation = 3

Evaluate Outcomes

Recommendation 29:
Evaluate on an ongoing basis whether the individual and family goals for pain relief, comfort and function have been met and maintained for as much of the time as possible.

Modify the plan if the goals have not been met and/ or maintained.
Level of Recommendation = 3

Documentation

Recommendation 30:
Document on a systematic pain record:
- all interventions
- patient outcomes
- effect of pharmacological and non-pharmacological interventions
- changes in the drug regimen
- patient or advocate refusals of pain relief measures that are offered, giving reasons if possible

Utilize this record to communicate with members of the healthcare team
Level of Recommendation = 3

VALIDATION

In February 2005, a committee of health care professionals with expertise in clinical practice and research in pain assessment and management from acute care, personal care and long term care sectors, convened under the auspices of the Winnipeg Regional Health Authority.

The first task of the committee was to identify and review existing literature and clinical practice guidelines in order to build on the current understanding of pain assessment, and to reach consensus on the scope and content of the guideline. A systematic literature search in addition to a structured Internet search was completed. The committee decided to amalgamate existing guidelines to create a document that would have clinical utility for health care providers identified in the scope of the document.

Each identified guideline was reviewed by the committee members and compared to determine its relative strengths and weaknesses. From this systematic evaluation, the committee decided to adopt the RNAO guideline, Assessment and Management of Pain, to formulate the base of the WRHA Pain Assessment Clinical Practice Guideline, and incorporate recommendations from other guidelines as deemed appropriate.

EVALUATION & MONITORING

Stakeholders are encouraged to evaluate the implementation of the Clinical Pain Assessment/Management Guideline for feasibility of practice. Canadian accreditation standards give clear direction to health care facilities that ongoing assessment of the effectiveness of pain management is an expected component of the CCHSA evaluation (CCHSA, 1995). Evaluating and monitoring the quality of pain care can be achieved by identifying indicators in three areas, namely, structure, process and outcome components of care (RNAO, 2002).

- Structure of Care
  - Performance data include characteristics of health care professionals and organizations such as training, education, type of facility and ownership indicators;
    - Availability and access to physicians and/or nurses identified as pain specialists.
    - Qualifications and education of staff in pain assessment.
    - Organizational commitment to pain relief inclusive of policies and procedures for pain assessment and management such as standardized tools for pain assessment and daily pain monitoring, and pain adopted as the fifth vital sign in the health record.
- Process of Care
  - Process data describes the activities of the health care provider in the encounter between the patient and the provider such as tests ordered, medication prescribed, assessments completed and interventions implemented. Process data are considered credible if it can be demonstrated that variations in the attribute measured leads to a difference in outcomes. Process of Care indicators include:
    - Chart audits to evaluate the practice of providers in the appropriate treatment of pain.
    - Pain Intensity Scales measure the severity of pain and to evaluate the effect of treatment modalities.
    - Pain Relief Scale estimates the change in pain severity as a result of treatment modalities and evaluates the adequacy of pain treatment.
    - Pain Management Indexes evaluates the appropriateness of pain treatment by assessing congruence between the type of analgesic prescribed and the patients reported level of pain severity.
- Outcomes of Care
  - Outcome data refer to the patient's subsequent health status and may include items such as mortality, quality of life, improvement in symptoms or functional status and patient satisfaction. Outcome data indicators include;
    - Patient Satisfaction Scale.
    - Development of Policies and Procedures consistent with this CPG.
    - Evidence of documentation in client record consistent with CPG.

CONCLUSION

This Committee hopes this work will benefit those patients who require effective pain management to maintain their dignity, functional capacity and overall quality of life.

REFERENCES

Altilio, Terry (2004). Pain and Symptom Management: An Essential Role for Social Work. In *Living with Dying*, J. Berzoff and P. Silverman, 380-408. New York: Columbia University Press.

American Medical Directors Association (2003). *Clinical Practice Guideline: Pain Management in the Long-Term Care Setting*. Columbia, MD: American Medical Directors Association.

Assiniboine Regional Health Authority (2005). *Palliative Care Program Manual: Pain Management.* Souris, Manitoba: Assiniboine Regional Health Authority.

Ministry of Health, Singapore (2003). *Clinical Practice Guidelines: Cancer Pain.* Republic of Singapore: Ministry of Health.

National Coalition for Cancer Research, website accessed July 25/ 06. Available at: http://www.cancercoalition.org/pain.html)

National Pharmaceutical Council, Inc. (2001). *Pain: Current Understanding of Assessment, Management, and Treatments.* Reston, VA: National Pharmaceutical Council, Inc.

Portenoy, R. K. & Hagen, N. A. (1991). Breakthrough cancer pain: definition and manifestations. *Primary Care Cancer*, *April*, 27-33.

Portenoy, R.K. & Hagen, N. A. (1990). Breakthrough pain: definition, prevalence and characteristics. *Pain, 41*, 273-281.

Registered Nurses Association of Ontario (2002). *Assessment and Management of Pain.* Toronto, Canada: Registered Nurses Association of Ontario. Available at: http://www.rnao.org/

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Appendix A

Pain Assessment Tools for Children Unable to Verbalize Presence of Pain

- The Face, Legs, Activity, Cry and Consolability Pain Assessment Tool (the FLACC)
- Non-communicating Children's Pain Checklist – Revised (NCCPC-R)
- Non-communicating Children's Pain Checklist – Post Op Version (NCCPC-PV)

FLACC Behavioral Scale

Categories	Scoring		
	0	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.			

FLACC Behavioral Pain Scale

Patients who are awake: Observe for at least 2-5 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone.
Initiate consoling interventions if needed.
Patients who are asleep: Observe for at least 5 minutes or longer. Observe body and legs uncovered. If possible reposition the patient. Touch the body and assess for tenseness and tone.

Face

Score 0 points if patient has a relaxed face, eye contact and interest in surroundings.
Score 1 point if patient has a worried look to face, with eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed.
Score 2 points if patient has deep furrows in the forehead, with closed eyes, open mouth and deep lines around nose/lips.

Legs

Score 0 points if patient has usual tone and motion to limbs (legs and arms).
Score 1 point if patient has increase tone, rigidity, tense, intermittent flexion/extension of limbs.
Score 2 points if patient has hyper tonicity, legs pulled tight, exaggerated flexion/extension of limbs, tremors

Activity

Score 0 points if patient moves easily and freely, normal activity/restrictions
Score 1 point if patient shifts positions, hesitant to move, guarding, tense torso, pressure on body part.
Score 2 points if patient is in fix position, rocking, side-to-side head movement, rubbing body part.

Cry

Score 0 points if patient has no cry/moan awake or asleep.
Score 1 point if patient has occasional moans, cries, whimpers, sighs.
Score 2 points if patient has frequent/continuous moans, cries, grunts.

Consolability

Score 0 points if patient is calm and does not require consoling.
Score 1 point if patient responds to comfort by touch or talk in ½ - 1 minute.
Score 2 points if patient requires constant comforting or unable to console.

Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decision making regarding treatment of pain requires careful consideration of the context in which the pain behaviors were observed.

Each category is scored on the 0-2 scale which results in a total score of 0-10
Assessment of Behavioral Score:

0 = relaxed and comfortable
1-3 = Mild discomfort
4-6 – Moderate pain
7-10 = Severe discomfort/pain

Non-communicating Children's Pain Checklist – Revised (NCCPC-R)

NAME:_____ UNIT/FILE #: _____ DATE:_____ (dd/mm.yy)

OBSERVER:_____ START TIME:_____AM/PM STOP TIME:_____AM/PM

How often has this child shown these behaviours in the last 2 hours? Please circle a number for each item. If an item does not apply to this child (for example, this child does not eat solid food or cannot reach with his/her hands), then indicate "not applicable" for that item.

0 = NOT AT ALL	1 = JUST A LITTLE	2 = FAIRLY OFTEN	3 = VERY OFTEN	NA = NOT APPLICABLE

I. Vocal					
1. Moaning, whining, whimpering (fairly soft)	0	1	2	3	NA
2. Crying (moderately loud)	0	1	2	3	NA
3. Screaming/yelling (very loud)	0	1	2	3	NA
4. A specific sound or word for pain (e.g., a word, cry or type of laugh)	0	1	2	3	NA
II. Social					
5. Not cooperating, cranky, irritable, unhappy	0	1	2	3	NA
6. Less interaction with others, withdrawn	0	1	2	3	NA
7. Seeking comfort or physical closeness	0	1	2	3	NA
8. Being difficult to distract, not able to satisfy or pacify	0	1	2	3	NA
III. Facial					
9. A furrowed brow	0	1	2	3	NA
10. A change in eyes, including: squinching of eyes, eyes opened wide, eyes frowning	0	1	2	3	NA
11. Turning down of mouth, not smiling	0	1	2	3	NA
12. Lips puckering up, tight, pouting, or quivering	0	1	2	3	NA
13. Clenching or grinding teeth, chewing or thrusting tongue out	0	1	2	3	NA
IV. Activity					
14. Not moving, less active, quiet	0	1	2	3	NA
15. Jumping around, agitated, fidgety	0	1	2	3	NA
V. Body and Limbs					
16. Floppy	0	1	2	3	NA
17. Stiff, spastic, tense, rigid	0	1	2	3	NA
18. Gesturing to or touching part of the body that hurts	0	1	2	3	NA
19. Protecting, favoring or guarding part of the body that hurts	0	1	2	3	NA
20. Flinching or moving the body part away, being sensitive to touch	0	1	2	3	NA
21. Moving the body in a specific way to show pain (e.g. head back, arms down, curls up, etc.)	0	1	2	3	NA
VI. Physiological					
22. Shivering	0	1	2	3	NA
23. Change in color, pallor	0	1	2	3	NA
24. Sweating, perspiring	0	1	2	3	NA
25. Tears	0	1	2	3	NA
26. Sharp intake of breath, gasping	0	1	2	3	NA
27. Breath holding	0	1	2	3	NA
VII. Eating/Sleeping					
28. Eating less, not interested in food	0	1	2	3	NA
29. Increase in sleep	0	1	2	3	NA
30. Decrease in sleep	0	1	2	3	NA

SCORE SUMMARY:

Category:	I	II	III	IV	V	VI	VII	TOTAL
Score:								

USING THE NCCPC-R

The NCCPC-R was designed to be used for children, aged 3 to 18 years, who are unable to speak because of cognitive (mental/intellectual) impairments or disabilities. It can be used *whether or not* a child has physical impairments or disabilities. Descriptions of the types of children used to validate the NCCPC-R can be found in: Breau, L.M., McGrath, P.J., Camfield, C.S. & Finley, G.A. (2002). Psychometric Properties of the Non-communicating Children's Pain Checklist-Revised. *Pain, 99,* 349-357. The NCCPC-R was designed to be used without training by parents and caregivers (carers). It can also be used by other adults who are not familiar with a specific child (do not know them well).

The NCCPC-R may be freely copied for clinical use or use in research funded by not-for-profit agencies. For-profit agencies should contact Lynn Breau: Pediatric Pain Research, IWK Health Centre, 5850 University Avenue, Halifax, Nova Scotia Canada, B3J 3G9 (lbreau@ns.sympatico.ca).

The NCCPC-R was intended for use for short or long-term pain in the child's home or in a long-term residential setting. If suspected *pain after surgery or pain due to procedures conducted in hospital* are the reason for measuring pain, the **Non-communicating Children's Pain Checklist – Postoperative Version** should be used. It can be obtained by contacting Lynn Breau. Information regarding the NCCPC-PV can be found in: Breau, L.M., Finley, G.A., McGrath, P.J. & Camfield, C.S. (2002). Validation of the Non-Communicating Children's Pain Checklist - Postoperative Version. *Anesthesiology, 96* (3), 528-535.

ADMINISTRATION:

To complete the NCCPC-R, base your observations on the child's behavior over the past **two hours**. ***It is not necessary to watch the child continuously for this period.*** However, it is recommended that the observer be in the child's presence for the majority of this time (e.g.; be in the same room with the child). Although shorter observation periods may be used, the cut-off scores described below may not apply.

Eating/Sleeping Subscale: Items on the Eating/Sleeping subscale may not occur during the two-hour observation. In this case, the rating should be based on the child's behavior over the day of the observation.

All other subscales: At the end of the observation time, indicate how frequently (how often) each item was seen or heard. This should not be based on the child's typical behavior or in relation to what he or she usually does. A guide for deciding the frequency of items is below:

0	=	Not present at all during the observation period. (Note if the item is not present because the child is not capable of performing that act, it should be scored as "NA").
1	=	Seen or heard rarely (hardly at all), but is present.
2	=	Seen or heard a number of times, but not continuous (not all the time).
3	=	Seen or heard often, almost continuous (almost all the time); anyone would easily notice this if they saw the child for a few moments during the observation time.
NA	=	Not applicable. This child is not capable of performing this action.

SCORING:

1. Add up the scores for each subscale and enter below that subscale number in the Score Summary at the bottom of the sheet. Items marked "NA" are scored as "0" (zero).
2. Add up all subscale scores for Total Score.
3. Check whether the child's score is greater than the cut-off score.

CUT-OFF SCORE:

Based on the scores of 71 children aged 3 to 18 (Breau, McGrath, Camfield & Finley, 2002), a **Total Score of 7 or more** indicates a child has pain. This was accurate in the study group 84% of the time. A Total Score of 6 or less indicates a child does not have pain. This was correct in the study group 77% of the time.

USE OF CUT-OFF SCORES:

As with all observational pain tools, caution should be taken in using cut-off scores because they may not be 100% accurate. They should not be used as the only basis for deciding whether a child should be treated for pain. In some cases children may have lower scores when pain is present. For more detailed instructions for use of the NCCPC-R in such situations, please refer to the full manual, available from Lynn Breau: Pediatric Pain Research, IWK Health Centre, 5850 University Avenue, Halifax, Nova Scotia Canada, B3J 3G9 (lbreau@ns.sympatico.ca).

Non-communicating Children's Pain Checklist – Postoperative Version (NCCPC-PV)

NAME:_____	UNIT/FILE #: _____	DATE:_____ (dd/mm/yy)
OBSERVER:_____	START TIME:_____AM/PM	STOP TIME:_____AM/PM

How often has this child shown these behaviours in the last 10 minutes? Please circle a number for each behaviour. If an item does not apply to this child (for example, this child cannot reach with his/her hands), then indicate "not applicable" for that item.

0 = NOT AT ALL	1 = JUST A LITTLE	2 = FAIRLY OFTEN	3 = VERY OFTEN	NA = NOT APPLICABLE

I. Vocal					
1. Moaning, whining, whimpering (fairly soft)	0	1	2	3	NA
2. Crying (moderately loud)	0	1	2	3	NA
3. Screaming/yelling (very loud)	0	1	2	3	NA
4. A specific sound or word for pain (e.g., a word, cry or type of laugh)	0	1	2	3	NA
II. Social					
5. Not cooperating, cranky, irritable, unhappy	0	1	2	3	NA
6. Less interaction with others, withdrawn	0	1	2	3	NA
7. Seeking comfort or physical closeness	0	1	2	3	NA
8. Being difficult to distract, not able to satisfy or pacify	0	1	2	3	NA
III. Facial					
9. A furrowed brow	0	1	2	3	NA
10. A change in eyes, including: squinching of eyes, eyes opened wide, eyes frowning	0	1	2	3	NA
11. Turning down of mouth, not smiling	0	1	2	3	NA
12. Lips puckering up, tight, pouting, or quivering	0	1	2	3	NA
13. Clenching or grinding teeth, chewing or thrusting tongue out	0	1	2	3	NA
IV. Activity					
14. Not moving, less active, quiet	0	1	2	3	NA
15. Jumping around, agitated, fidgety	0	1	2	3	NA
V. Body and Limbs					
16. Floppy	0	1	2	3	NA
17. Stiff, spastic, tense, rigid	0	1	2	3	NA
18. Gesturing to or touching part of the body that hurts	0	1	2	3	NA
19. Protecting, favoring or guarding part of the body that hurts	0	1	2	3	NA
20. Flinching or moving the body part away, being sensitive to touch	0	1	2	3	NA
21. Moving the body in a specific way to show pain (e.g. head back, arms down, curls up, etc.)	0	1	2	3	NA
VI. Physiological					
22. Shivering	0	1	2	3	NA
23. Change in color, pallor	0	1	2	3	NA
24. Sweating, perspiring	0	1	2	3	NA
25. Tears	0	1	2	3	NA
26. Sharp intake of breath, gasping	0	1	2	3	NA
27. Breath holding	0	1	2	3	NA

SCORE SUMMARY:

Category:	I	II	III	IV	V	VI	TOTAL
Score:							

USING THE NCCPC-PV

The NCCPC-PV was designed to be used for children, aged 3 to 18 years, who are unable to speak because of cognitive (mental/intellectual) impairments or disabilities. It can be used *whether or not* a child has physical impairments or disabilities. Descriptions of the types of children used to validate the NCCPC-PV can be found in: Breau, L.M., Finley, G.A., McGrath, P.J. & Camfield, C.S. (2002). Validation of the Non-Communicating Children's Pain Checklist - Postoperative Version. *Anesthesiology, 96* (3), 528-535. The NCCPC-PV was designed to be used without training by parents and caregivers (carers), or by other adults who are not familiar with a specific child (do not know them well).

The NCCPC-PV may be freely copied for clinical use or use in research funded by not-for-profit agencies. For-profit agencies should contact Lynn Breau: Pediatric Pain Research, IWK Health Centre, 5850 University Avenue, Halifax, Nova Scotia Canada, B3J 3G9 (lbreau@ns.sympatico.ca).

The NCCPC-PV was intended for use for pain after surgery or due to other procedures conducted in hospital. If short or long-term pain is suspected for a child at home or in a long-term residential setting, the **Non-communicating Children's Pain Checklist – Revised** may be used. It can be obtained by contacting Lynn Breau. Information regarding the NCCPC-R can be found in: Breau, L.M., McGrath, P.J., Camfield, C.S. & Finley, G.A. (2002). Psychometric Properties of the Non-communicating Children's Pain Checklist-Revised. *Pain, 99,* 349-357.

ADMINISTRATION:

To complete the NCCPC-R, base your observations on the child's behavior over **10 minutes**. ***It is not necessary to watch the child continuously for this period.*** However, it is recommended that the observer be in the child's presence for the majority of this time (e.g.; be in the same room with the child). Although shorter observation periods may be used, the cut-off scores described below may not apply.

At the end of the observation time, indicate how frequently (how often) each item was seen or heard. This should not be based on the child's typical behavior or in relation to what he or she usually does. A guide for deciding the frequency of items is below:

0	=	Not present at all during the observation period. (Note if the item is not present because the child is not capable of performing that act, it should be scored as "NA").
1	=	Seen or heard rarely (hardly at all), but is present.
2	=	Seen or heard a number of times, but not continuous (not all the time).
3	=	Seen or heard often, almost continuous (almost all the time); anyone would easily notice this if they saw the child for a few moments during the observation time.
NA	=	Not applicable. This child is not capable of performing this action.

SCORING:

1. Add up the scores for each subscale and enter below that subscale number in the Score Summary at the bottom of the sheet. Items marked "NA" are scored as "0" (zero).
2. Add up all subscale scores for Total Score.
3. Check whether the child's score is greater than the cut-off score.

CUT-OFF SCORE:

Based on the scores of 24 children aged 3 to 18 (Breau, Finley, McGrath & Camfield, 2002), a **Total Score of 11 or more** indicates a child has **moderate to severe pain**. Based on unpublished data from this same sample, a ***Total score of 6-10*** indicates a child has **mild pain**. When parents and caregivers completed the NCCPC-PV in hospital for the study group, this was accurate 88% of the time. When other observers completed the NCCPC-PV, this was accurate 75% of the time.

USE OF CUT-OFF SCORES:

As with all observational tools, caution should be taken in using cut-off scores, because they may not be 100% accurate. They should not be used as the only basis for deciding whether a child should be treated for pain. In some cases children may have lower scores when pain is present. For more detailed instructions for use of the NCCPC-PV in such situations, please refer to the full manual, available from Lynn Breau: Pediatric Pain Research, IWK Health Centre, 5850 University Avenue, Halifax, Nova Scotia Canada, B3J 3G9 (lbreau@ns.sympatico.ca).

Appendix B

Pain Assessment Tools for Adults Unable to Verbalize Presence of Pain

- Checklist of Nonverbal Pain Indicators (CNPI)
- The Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN)

Checklist of Nonverbal Pain Indicators

(Write a 0 if the behavior was not observed, and a 1 if the behavior occurred even briefly during activity or rest.)

	With Movement	Rest
1. Vocal complaints: Non-verbal (Expression of pain, not in words, moans, groans, grunts, cries, gasps, sighs)	____	____
2. Facial Grimaces/Winces (Furrowed brow, narrowed eyes, tightened lips, jaw drop, clenched teeth, distorted expressions).	____	____
3. Bracing (Clutching or holding onto side rails, bed, tray table, or affected area during movement)	____	____
4. Restlessness (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)	____	____
5. Rubbing: (Massaging affected area)	____	____
(In addition, record Verbal complaints).		
6. Vocal complaints: Verbal (Words expressing discomfort or pain, "ouch" "that hurts"; cursing during movement, or exclamations of protest: "stop", "that's enough".)	____	____
Subtotal Scores	____	____
Total Score	____	

Feldt, K. S. (1996). Treatment of pain in cognitively impaired versus cognitively intact post hip fractured elders. (Doctoral dissertation, University of Minnesota, 1996). Dissertation Abstracts International, 57-09B, 5574.

Feldt, K.S. (2000). Checklist of Nonverbal Pain Indicators. Pain Management Nursing, 1 (1), 13-21.

NOPPAIN

(Non-Communicative Patient's Pain Assessment Instrument

Activity Chart Check List

Name of Evaluator _____

Name of Resident: _____

Date: _____

Time: _____

DIRECTIONS: Nursing assistant should complete at least 5 minutes of daily care activities for the resident while observing for pain behaviors. Both pages of this form should be completed immediately following care activities

	Did you do this? Check Yes or No	Did you see pain when you did this? Check Yes or No
(a) Put resident in bed OR saw resident lying down	☐ YES ☐ NO	☐ YES ☐ NO
(b) Turned resident in bed	☐ YES ☐ NO	☐ YES ☐ NO
(c) Transferred resident (bed to chair, chair to bed, standing or wheelchair to toilet	☐ YES ☐ NO	☐ YES ☐ NO
(d) Sat resident up (bed or chair) OR saw resident sitting	☐ YES ☐ NO	☐ YES ☐ NO
(e) Dressed resident	☐ YES ☐ NO	☐ YES ☐ NO
(f) Fed resident	☐ YES ☐ NO	☐ YES ☐ NO
(g) Helped resident stand OR saw resident stand	☐ YES ☐ NO	☐ YES ☐ NO
(h) Helped resident walk OR saw resident walk	☐ YES ☐ NO	☐ YES ☐ NO
(i) Bathed resident OR gave resident sponge bath	☐ YES ☐ NO	☐ YES ☐ NO

ASK THE PATIENT: Are you in pain? ☐yes ☐no

ASK THE PATIENT: Do you hurt? ☐yes ☐no

Pain Response (What did you see and hear during care?)

Pain Words?
- "That hurts!" - "Ouch!"
- Cursing - "Stop that!"

☐ YES ☐ NO

How intense were the pain words?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Pain Faces?
- grimaces - winces
- furrowed brow

☐ YES ☐ NO

How intense were the pain faces?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Bracing?
- rigidity - holding - guarding (especially during movement)

☐ YES ☐ NO

How intense was the bracing?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Pain Noises?
- moans - groans - grunts
- cries - gasps - sighs

☐ YES ☐ NO

How intense were the pain noises?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Rubbing?
- massaging affected area

☐ YES ☐ NO

How intense was the rubbing?

0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Restlessness?
- frequent shifting - rocking
- inability to stay still

☐ YES ☐ NO

How intense was the restlessness?

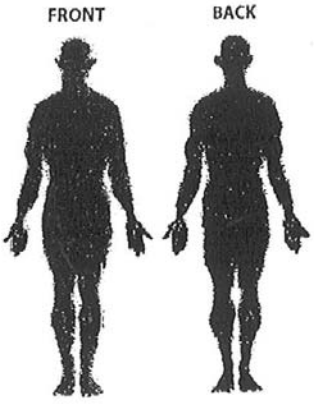
0 1 2 3 4 5

Lowest Possible Intensity — Highest Possible Intensity

Locate Problem Areas

Please "X" the site of any pain

Please "O" the site of any skin problems



NOPPAIN

(Non-Communicative Patient's Pain Assessment Instrument

Activity Chart Check List

Name of Evaluator _____

Name of Resident: _____

Date: _____

Time: _____

Rate the resident's pain at the highest level you saw it at during care. **(circle your answer)**

Pain is almost unbearable

Very bad pain

Quite bad pain

Moderate pain

Little pain

No pain

Appendix C

WRHA Pain Assessment Documentation Tools

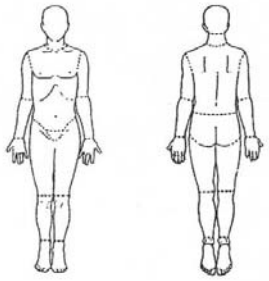
- Pain Assessment Tool (Adult)
- Pain Flow Sheet

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

PAIN ASSESSMENT TOOL (Adult)

CLIENT HEALTH RECORD #
CLIENT SURNAME
GIVEN NAME
DATE OF BIRTH
SEX
MHSC #
PHIN #

1. Please mark the area of pain on the drawing. If you have more than one pain, label them A, B, C, etc.



Rate your pain on a scale from 0 to 10.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

DATE

	PAIN A	PAIN B	PAIN C
A) Rate your pain on a scale from 0 - 10? • At the present time • At its worst • At its least • Person's acceptable pain level	/10 /10 /10 /10	/10 /10 /10 /10	/10 /10 /10 /10
B) Check the words that best describe the kind of pain you have. Check as many words as apply.	☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Sharp ☐ Stabbing ☐ Deep ☐ Cramping ☐ Surface ☐ Pins and Needles ☐ Other _____	☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Sharp ☐ Stabbing ☐ Deep ☐ Cramping ☐ Surface ☐ Pins and Needles ☐ Other _____	☐ Dull Ache ☐ Throbbing ☐ Burning ☐ Sharp ☐ Stabbing ☐ Deep ☐ Cramping ☐ Surface ☐ Pins and Needles ☐ Other _____
C) Does the pain radiate/travel anywhere?	☐ YES ☐ NO If YES, where _____	☐ YES ☐ NO If YES, where _____	☐ YES ☐ NO If YES, where _____
D) How & when did the pain begin?			
E) How often do you have the pain?	☐ All the time ☐ Many times a day ☐ Once a day ☐ Other _____	☐ All the time ☐ Many times a day ☐ Once a day ☐ Other _____	☐ All the time ☐ Many times a day ☐ Once a day ☐ Other _____
F) How long does the pain usually last?	☐ Seconds ☐ Minutes ☐ Hours ☐ Constant	☐ Seconds ☐ Minutes ☐ Hours ☐ Constant	☐ Seconds ☐ Minutes ☐ Hours ☐ Constant
G) What makes the pain worse?	☐ Walking ☐ Dressing Changes ☐ Moving ☐ Other (describe) _____	☐ Walking ☐ Dressing Changes ☐ Moving ☐ Other (describe) _____	☐ Walking ☐ Dressing Changes ☐ Moving ☐ Other (describe) _____
H) Is your pain worse at a certain time of day? When?	☐ Morning ☐ Evening ☐ Afternoon ☐ Night	☐ Morning ☐ Evening ☐ Afternoon ☐ Night	☐ Morning ☐ Evening ☐ Afternoon ☐ Night
I) What makes the pain better?	☐ Heat ☐ Relaxation ☐ Cold ☐ Distraction ☐ Massage ☐ Lying Still ☐ Changing Position ☐ TENS, Physio, Acupuncture ☐ Other (describe) _____	☐ Heat ☐ Relaxation ☐ Cold ☐ Distraction ☐ Massage ☐ Lying Still ☐ Changing Position ☐ TENS, Physio, Acupuncture ☐ Other (describe) _____	☐ Heat ☐ Relaxation ☐ Cold ☐ Distraction ☐ Massage ☐ Lying Still ☐ Changing Position ☐ TENS, Physio, Acupuncture ☐ Other (describe) _____

DRAFT #3 FORM #????? 04/06 Adapted from Calgary Inter-Agency Pain Assessment Tool

	MEDICATION	HOW OFTEN?
2. What medication(s) are you taking for pain now (Include prescription, non-prescription, herbal, street drugs)? How often are you taking them?		

3. On average, how much alcohol do you drink in a week? _____
4. What medication(s) best control your pain? _____
5. What medication(s) have not helped? _____
6. Has the pain or treatment caused any other symptoms?
   - ☐ Nausea ☐ Sleep Problems ☐ Anxiety ☐ Loss of Appetite ☐ Problems Thinking
   - ☐ Drowsiness ☐ Diarrhea ☐ Problems with Balance/Falls ☐ Dizziness ☐ Constipation
   - ☐ Change in Mood ☐ Other (describe) _____
7. Does pain affect your:

	YES	NO	Comments
Physical Activity/Walking	☐	☐	
Ability to Care for Yourself	☐	☐	
Social Activities	☐	☐	
Job/Finances	☐	☐	
Parenting	☐	☐	
Intimate/Sexual Relationships	☐	☐	
Religious/Spiritual Beliefs	☐	☐	
Self-Image	☐	☐	

8. What has your doctor told you about the cause of your pain? _____
9. What do you think is the cause of your pain? _____
10. What does the pain mean to you? _____
11. How do you express your pain? _____
12. How do you cope with your pain? _____
13. What concerns do you have about your pain management?
    - ☐ Money to pay for medications ☐ Fear of becoming addicted to pain medications
    - ☐ Side effects of pain medications ☐ Communicating or explaining your pain to others
    - ☐ Getting prescriptions picked up ☐ Need to save some pain medication in case the pain gets worse
    - ☐ Other (describe) _____
14. What concerns do your family and/or caregivers have? _____
15. What do you feel would help you with your pain? _____
16. How do you prefer to get information about your pain/pain management stategies? _____
17. Is there anything else you want to tell us about your pain? _____

Assessor's Observations Relevant to this Pain Problem (e.g. objective assessment, affect, guarding, grimacing, vital signs)

_____

SIGNATURE OF ASSESSOR

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg
Caring for Health | *À l'écoute de notre santé*

CLIENT HEALTH RECORD #
CLIENT SURNAME
GIVEN NAME
DATE OF BIRTH
SEX
MHSC #
PHIN #

PAIN FLOW SHEET

			Date & Time							
Location	Where is the pain?									
	Does pain radiate? *Yes/No*		Y / N							
Intensity	Rate Pain on a Scale of 0 - 10	Worst in past 24 hours	/10	/10	/10	/10	/10	/10	/10	
		Best in past 24 hours	/10	/10	/10	/10	/10	/10	/10	
		At rest	/10	/10	/10	/10	/10	/10	/10	
		On movement	/10	/10	/10	/10	/10	/10	/10	
		With dressing changes	/10	/10	/10	/10	/10	/10	/10	
Quality	Dull Ache		Y / N							
	Burning		Y / N							
	Stabbing		Y / N							
	Cramping		Y / N							
	Throbbing		Y / N							
	Pins and Needles		Y / N							
	Sharp		Y / N							
	Deep		Y / N							
	Surface		Y / N							
	Other *describe*									
Management Strategies	# of breakthroughs in last 24 hours									
	Use of non-pharmacological interventions *Yes/No Ineffective/Effective*		Y / N / I / E							
Side Effects of Pain Medication	Nausea		Y / N							
	Sleep Problems		Y / N							
	Anxiety		Y / N							
	Loss of Appetite		Y / N							
	Problems Thinking		Y / N							
	Drowsiness		Y / N							
	Diarrhea		Y / N							
	Problems with Balance/Falls		Y / N							
	Dizziness		Y / N							
	Constipation		Y / N							
	Change in Mood		Y / N							
	Other *describe*									
Additional Note in IPN			Y / N							
Initials										

DRAFT #3 FORM #????? 04/06

Appendix D

Pain Intensity Rating Tools

This appendix includes recommended pain intensity rating tools:

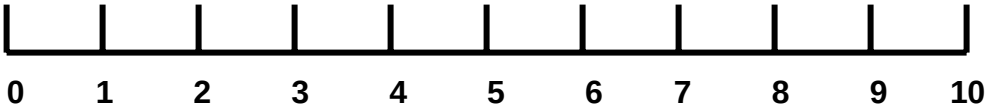
- Visual Analogue Scale (VAS)
- Numeric Rating Scale (NRS)
- Verbal Rating Scale (VRS)
- Present Pain Intensity Scale (PPI)
- Wong-Baker FACES Pain Rating Scale

Visual Analogue Scale (VAS)

No Pain **Worst Possible Pain**

The patient indicates intensity of pain on a 10cm line marked from “No Pain” at one end to “Worst Possible Pain” it could be at the other end.

Numeric Rating Scale (NRS)



The patient rates pain on a scale from zero (“0”) to ten (“10”)

Verbal Rating Scale (VRS)

The patient answers the following question using one of the answers provided:

How strong is your pain?

1. **No pain**
2. **Mild**
3. **Moderate**
4. **Severe**

Present Pain Intensity Scale (PPI)

The patient answers the following question using one of the answers provided:

How strong is your pain?

1. **Mild**
2. **Discomforting**
3. **Distressing**
4. **Horrible**
5. **Excruciating**

Wong-Baker FACES Pain Rating Scale

Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the person to choose face that best describes own pain and record the appropriate number.

Original Instructions: Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.
Face 0 is very happy because he doesn't hurt at all.
Face 1 hurts just a little bit.
Face 2 hurts a little more.
Face 3 hurts even more.
Face 4 hurts a whole lot.
Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad.

Ask the person to choose the face that best describes how he is feeling.
Rating scale is recommended for persons age 3 years and older.

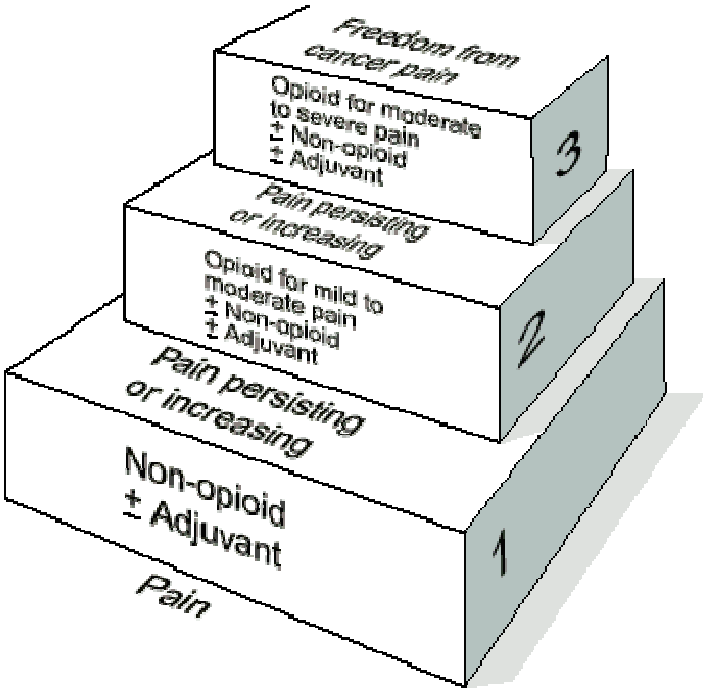
Appendix E

World Health Organization's (WHO) Analgesic Ladder

World Health Organization's (WHO) Analgesic Ladder

If pain occurs, there should be prompt oral administration of drugs in the following order: nonopioids (aspirin and paracetamol); then, as necessary, mild opioids (codeine); then strong opioids such as morphine, until the patient is free of pain. To calm fears and anxiety, additional drugs – "adjuvants" – should be used. To maintain freedom from pain, drugs should be given "by the clock", that is every 3-6 hours, rather than "on demand" This three-step approach of administering the right drug in the right dose at the right time is inexpensive and 80-90% effective. Surgical intervention on appropriate nerves may provide further pain relief if drugs are not wholly effective.

WHO Analgesic Ladder:



Appendix F

Sample Pain Diaries

- Deer Lodge Centre Patient/ Resident Pain Diary
- CancerCare Manitoba Pain & Symptom Management Diary

DEER LODGE CENTRE

Making lives better

Date	Time	Rate level of pain: 1-10	What was I doing?	How was I feeling? (anxiety, fear/tension)	Did you receive something for pain? yes/no	Level of pain after 30 min – 1 hour 0-10

0 1 2 3 4 5 6 7 8 9 10

No pain

Worse Pain

FORM # 0413 (01/04)

Patient/Resident Pain Diary

CancerCare Manitoba

PAIN & SYMPTOM MANAGEMENT DIARY

_____

Name:_____

Date started:_____

Date completed:_____

_____

Nurse:_____
Phone:_____

Doctor:_____

Symptom Management
Nurse:_____

Phone:_____

This diary can be used to keep track of the symptoms you experience in a one-week period.

This will give your doctor and nurse a snapshot of your symptom control each day.

There are several symptoms which are included in this diary. They are all important in evaluating the drugs you are receiving, or if any changes are necessary.

PAIN

NAUSEA

DROWSINESS

BOWEL MOVEMENT

BREAKTHROUGH DOSE

For those symptoms with a box, please rate them on a 10-point scale (0 = no symptom, 10 = worst possible symptom).

Please rate your symptoms twice a day, morning and evening.

For those symptoms with a yes/no answer, please circle the appropriate answer in the evening of each day.

If you answer yes to a breakthrough dose, please fill out the opposite side of this diary.

Day		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	Pain														
	Nausea														
	Drowsiness														
	Bowel Movement	Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No	
	Breakthrough Dose	Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No		Yes / No	

0 1 2 3 4 5 6 7 8 9 10

No symptom — Worst possible symptom

Please rate your symptom with a number between 0 and 10 and put the number in the box for the appropriate day. If the box has a yes / no, please circle the appropriate answer in the evening of each day.