Pain Assessment Across the Lifespan (and the Span of Care)

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Objectives

After this presentation, the participant should be able to:

1. Identify the key elements of pain assessment for all patients.
2. Identify tools for assessing pain in subpopulations of patients.
3. State the multidimensional features of pain assessment including the comorbidities of chemical dependency and mental illness.
Why Talk about Assessment?

- Pain assessment and reassessment provide the foundation of good pain management and sets the stage for planning, implementation and evaluation of care.
- Lack of pain assessment is a major cause of inadequate pain management.
- Assessment is a *process*, not an instrument or a score.
- There is no such thing as a patient who can’t be assessed.

Organization of the Presentation

- Will use the “Hierarchy of Pain Assessment” to organize our thoughts
  - What are the universal features needed in a good pain assessment?
  - What assessment features distinguish the four major types of pain?
  - What distinguishes acute from chronic pain?
  - How does mental illness or substance abuse disorder factor into the assessment of a patient’s pain experience?
1. **Patient’s self-report** is the most valid and reliable measure of pain existence and intensity.
2. Pathologic **conditions** or procedures **that usually cause pain**
3. **Observe Behaviors** (e.g. facial expression, body movements, crying)
4. **Proxy ratings.** Report of pain from parent/family/others close to patient.
5. **Physiologic measures:** Least sensitive measure of pain existence and intensity. Conclusion: inappropriate to rely solely on physiologic data to measure pain.

*Van Cleve et al. (1996)*

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**Hierarchy of Pain Assessment**

*In Order of Most Reliable to Least Reliable Measures*

**#1. Self Report**

- Pain is a subjective, emotional experience
- When clinicians do not obtain pain ratings from patients, they are likely to underestimate moderate to severe pain.
- Clinicians don't always accept what the patient tells them:
  - when behaviors don’t match self-report.
  - In 1994, nurses in long-term care facilities believed 25% of the patients exaggerated the intensity of their cancer pain.
Self Reported Elements of a Pain Assessment

- **Location:** *where, more than one location?*
- **Duration:** *when did it start?*
- **Intensity:** *how much does it hurt?*
- **Description:** *what does it feel like?*
- **Aggravating/relieving factors:** *what helps/or doesn’t help?*

Self Reported Elements of a Pain Assessment (cont)

- **Functional impairment:** *Does pain interfere with ADLs, fulfilling roles?*
- **Psychosocial Assessment:** *Anxious, depressed?*
- **Beliefs and attitudes about pain:** *e.g. Expected with aging? Punishment?*
- **Pain Goals:** *Realistic? Talking about intensity or functionality?*
Acute pain: elicited by injury of body tissues and activation of nociceptive transducers at site of local tissue damage. Lasts for relatively limited time and resolves with healing of underlying pathology.

Acute pain has a **beginning**, **a middle** and a **predictable end**.
Duration:
Acute vs. Chronic/Persistent Pain

• **Chronic pain**: May be elicited by injury or disease, but persists for a long period of time with low level of underlying pathology that does not explain the presence and extent of pain.

• Chronic pain affects at least 116 million American adults- more than total affected by heart disease, cancer, and diabetes combined. (IOM report, June 2011)

• Currently available treatments are rarely capable of totally eliminating chronic pain. Because the pain persists, it is likely that **environmental, emotional, and cognitive factors will contribute to persistence of pain** and associated illness behaviors.

Pain Intensity

- **Pain scores are only one part** of a good pain assessment
- Recognize that pain intensity is a “uni-modal” measure of pain.
- Chronic pain intensity scores do not necessarily correspond to pain behaviors, functioning and quality of life.
- Assess pain intensity with movement!
Uni-dimensional Intensity Assessment Tools

- Measure only one aspect of pain
- Fast, simple to use
- Easy to score
- Originally developed for research trials

Limitations
- Oversimplify pain
- Quantifying severe pain is difficult
- Decreased reliability at age extremes, with non-verbal & cognitively impaired

Numeric Pain Intensity Scale

<table>
<thead>
<tr>
<th>No pain</th>
<th>Moderate pain</th>
<th>Worst possible pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

Worst possible pain
0–10 Scale

- Valid and reliable for adults
- Valid in children 8 and over who can quantify or understand rank and order
- Easy to use
- Easy to track scores over time
- Patient must understand numerical concept

Appropriate Use of Pain Assessment Tools

- 1 in 3 nursing home residents with normal cognition could not use quantitative pain scale (0–10)
- Many elders prefer the “word” scale
- When asking questions, may have to use words other than “pain”: e.g. “hurt”, “ache”, “discomfort”
- Use a selected tool consistently for each individual

Pautex, S., et al., 2006
Pain Scales

- Do not use one person’s scores to compare with another.
- Be cautious in using only self-report scores to determine drug dosing.

Wong–Baker FACES Pain Rating Scale

0 1 2 3 4 5
No hurt Hurts little bit Hurts little more Hurts even more Hurts whole lot Hurts worst

Modified Faces Scale


Pain Intensity Rating Scales

Simple Descriptive Pain Intensity Scale¹
No pain | Mild pain | Moderate pain | Severe pain | Very severe pain | Worst possible pain

0-10 Numeric Pain Intensity Scale¹
0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst possible pain

Visual Analog Scale (VAS)²
No pain | Pain as bad as it could possibly be

¹ If used as a graphic rating scale, a 10 cm baseline is recommended.
² A 10-cm baseline is recommended for VAS scales.
Pain Thermometer
Used with permission, K. Herr, U. Iowa, 2005

- Pain as bad as it could be
- Extreme pain
- Severe pain
- Moderate pain
- Mild pain
- Slight pain
- No pain

Multi-dimensional Pain Assessment Tools

- Assess more than intensity
- Address the nature and location of pain
- Often used with a multidisciplinary approach to pain care

Examples
- McGill Pain Questionnaire
- Brief Pain Inventory
- Dartmouth Pain Questionnaire
- Multidimensional Pain Inventory
- Others
Types of Pain Described in Self Report

- **Nociceptive**
  - Arises from bone, joint, muscle, skin, or connective tissue.
  - Usually achy, throbbing in quality
  - Usually well localized

- **Neuropathic**

- **Inflammatory**

- **Psychogenic**

**Nociceptive Pain**

Arising from damage to normal tissue: responsive to non-opioids and opioids

**Somatic Pain**
- Arises from bone, joint, muscle, skin, or connective tissue.
- Usually achy, throbbing in quality
- Usually well localized

**Visceral Pain**
- Arises from visceral organs
- May be localized (e.g. tumor involvement in a hollow organ)
- May be poorly localized (e.g. myocardial pain that is referred)
### Neuropathic Pain

Abnormal processing of sensory input by peripheral or CNS: responsive to adjuvant analgesics

<table>
<thead>
<tr>
<th>Centrally Generated Pain</th>
<th>Peripherally Generated Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deafferentation pain: e.g. phantom pain,</td>
<td>Polyneuropathies: e.g. diabetic neuropathy, alcohol–nutritional neuropathy</td>
</tr>
<tr>
<td>Sympathetically maintained pain: CRPS I or CRPS II</td>
<td>Mononeuropathies: e.g. trigeminal neuralgia, nerve root compression or entrapment</td>
</tr>
</tbody>
</table>

### Pain Quality Descriptors Used by Patients

- **Nociceptive Pain**
  - Cramping
  - Crushing
  - Piercing
  - Pinching
  - Pounding
  - Pressure
  - Sharp/Stabbing
  - Spasms

- **Neuropathic Pain**
  - Pins and needles
  - Numb
  - Radiating
  - Burning
  - Shooting/electric shock
  - Stabbing
  - Tingling
  - Spasms
Nociceptive vs. Neuropathic Pain

LANSS: Leeds Assessment of Neuropathic Symptoms and Signs: 5 symptoms and 2 physical exam findings:
- Does pain feel like strange unpleasant sensations?
- Do painful areas look different?
- Area abnormally sensitive to touch?
- Sudden unexplained burst of pain?
- Skin temperature in painful area feel abnormal (e.g. hot, burning)?
- Does stroking skin with cotton produce pain?
- Does pinprick (23Ga) at affected area feel sharper or duller than normal skin?

Higher scores more likely neuropathic pain.

DN4= Neuropathic Pain Diagnostic Questionnaire: 4 questions. Easy to score.

(Arnstein P., 2010)

Inflammatory Pain
Responsive to Anti-Inflammatory Drugs and Opioids

- Injured tissues release activating substances that affect nociceptors
- May sensitize nerves to touch (allodynia)
- Examples of inflammatory pain: post-surgical wounds, infected sites, tumor infiltration
Psychogenic Pain
Associated with Psychological Disorders

Diagnosis made when organic causes of pain are ruled out. Based on signs and symptoms, not on etiology of pain. e.g.
- Somatoform disorder: characterized by pain as the predominant focus of clinical attention.
- PTSD: post traumatic stress disorder
- Factitious disorder: fabrication of subjective complaints, falsification of objective signs, self-inflicted condition

Evaluate impact of pain on physical function, quality of life and ability to perform ADLs
- Self care abilities
- ADLs across lifespan
- Ability to enjoy life, socialize, play
Functional Assessment: Pain’s effect

- Can you get up and down from the toilet?
- Can you go up and down steps, curbs, etc.?
- Can you dress, groom, bathe yourself?
- Have you fallen or almost fallen?
- Do you require help to do things you once did independently?
- Can you work, go to school?

Coping Assessment

- Previous experience
- Present attitude
- Presence of depression/anxiety
- Usual coping strategies
- Willingness to try new strategies
- Preferences and wishes
Spiritual Assessment

- Religious beliefs and practices related to health concerns
  - Do beliefs encourage or prevent participation in care?
- Beliefs related to pain and pain relief
  - Therapies that are forbidden?
- Evidence of spiritual/existential distress
- Desire for support or referral?

Assessing Pain in Persons with Sensory Alterations

- Use:
  - Larger print/pictures on assessment tools to account for declining vision
  - Tools with clear contrast between print and background colors
  - Patient’s vision and/or hearing aids
- Speak clearly, directly to patient to account for declining hearing
- Minimize background noises during interview to aid patient’s discernment of questions
Assessing Children

- **School aged children**
  - ≥ 5 years old, interview with or without parent
  - Usually able to accurately give own history & severity
  - Encourage to provide as much detail as possible about the experience

Assessing Children (cont)

- ** Adolescents**
  - Express genuine interest
  - Focus on the individual, not the problem
  - Confidential conversation is appropriate
  - Avoid silence...rarely useful
  - Avoid confrontation

- Keep informal and comfortable
- Usually able to provide similar information as an adult
Assessing Children (cont)

Use age & **developmentally appropriate** assessment tools

- **FACES**: 0-5 or 0-10 scale: Requires no reading or verbal skills. Disadvantages: sometime this scale is seen as measuring mood rather than pain. (>3 yrs age)
- **Eland color tool**: eight crayons presented randomly to child who **picks four colors** to represent most hurt to least hurt. (as young as 4 yrs age)

Assessing Children (cont)

- **Poker Chip**: 4 red chips placed horizontally in front of child. “How many pieces of hurt do you have?” (as young as 4 yrs age)

- **Oucher**: 6 photographs of children representing different levels of pain along 0-100 scale. (3-13 yrs age)
When a Patient Cannot Self-Report

• Treat pain if pathology or therapy causes pain for most people.
• Anticipate painful procedures: prevention now may decrease chronic pain later.

Hierarchy of Pain Assessment:
#2 Assume Pain for Conditions/Procedures that usually Cause Pain

• Treat pain if pathology or therapy causes pain for most people.
• Anticipate painful procedures: prevention now may decrease chronic pain later.
Pain Assessment Hierarchy: #3. Observe Pain Behaviors

• Select a tool that has been evaluated in the population and setting of interest.
• Behavioral tool that is scored does not equate the scoring of a self-report tool.
• Use behavioral pain tools to focus on behaviors that are indicators of pain: Increases or decreases in the number or intensity of behaviors suggest increasing or decreasing pain.

Behavioral Clues to Pain

- Facial expressions are poor indicators of pain in people who have been suffering from chronic pain syndromes.
  - Typical facial expression of acute pain illustrated by a wounded soldier

San Francisco Examiner photo by Kim Komenich, reprinted with permission
Examples of Behavioral Tools for Children

**CRIES:** 5 categories: crying, oxygen requirement to keep sats >95%, increased vital signs, expression, sleeplessness. Each category is scored 0-2 and added for total score 0-10. Tested in neonates for procedural and surgical pain.

**N-PASS:** Neonatal Pain, Agitation and Sedation Scale. Tested in premature neonates 23-40wk gestation.

**FLACC:** 5 categories observing facial expression, leg movement, activity level, cry, consolability. Each category is scored 0-2 and added for total score 0-10.

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### FLACC Pain Scale

<table>
<thead>
<tr>
<th>FACE</th>
<th>0: No particular expression or smile</th>
<th>1: Occasional grimace or frown, withdrawn/interested</th>
<th>2: Frequent to constant frown, clenched jaw, covering of face</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEGS</td>
<td>0: Normal position, leg relaxed</td>
<td>1: Uneasy, restless, tense</td>
<td>2: Kicking, OR Legs drawn up</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>0: Lying quietly, Normal position, Moves easily</td>
<td>1: Squirming, Shifting back/forth, Tense</td>
<td>2: Arched, Rigid, OR Jerking</td>
</tr>
<tr>
<td>CRY</td>
<td>0: No Cry, (Awake or Asleep)</td>
<td>1: Means or whispers, Occasional complaint</td>
<td>2: Crying loudly, Screams or acts, Frequent Complaints</td>
</tr>
<tr>
<td>CONSOLABILITY</td>
<td>0: Content, Relaxed</td>
<td>1: Resistant to occasional touching, hugging, or talking in Disturbed bed</td>
<td>2: Difficult to console or comfort</td>
</tr>
</tbody>
</table>

**Instructions:** 1. Rate patient in each of the five measurement categories  
2. Add together  
3. Document total pain score
Potential Cognitive Impairments

- Delirium
- Dementia
- Depression

Assessing Pain in Patients with Cognitive Impairment

- Do not assume patients with cognitive impairment cannot provide assessment information
- Be aware of patient’s sensory deficits
- Assume pain prevalence and severity is the same as for cognitively intact individuals
- Determine most appropriate pain assessment tool
Cognitive Impairment

- Behaviors associated with dementia may be secondary to pain or other unmet needs
  - Physical
  - Sensory
  - Psychological
  - Social
  - Environmental

- Pain may exacerbate confusion, agitation and other undesirable behaviors
- Generally verbal pain complaints decrease as cognitive impairment worsens

Pain Behaviors: Cognitively Impaired

- Facial expressions
  - Sad, frightened, distortion, closed/tightened eyes, rapid blinking, grimace

- Verbalizations – Vocalizations
  - Moan, groan, grunting, verbally abusive, calling out, chanting, crying, change in volume of voice

- Body movements
  - Rigid, tense, guarding, restless, pacing, rocking, tremors, gait/posture changes, restrictive movements
Pain Behaviors: Cognitively Impaired

- Interpersonal relationships
  - Changes with interactions, disruptive, withdrawn, resistive, avoidance
- Change in routine activities
  - Sudden refusal to participate in activities, decreased appetite or intake, increased wandering, wanting to rest more frequently
- Mental status
  - Changes in confusion, irritability, anxiety, depression

Pain Assessment Tools: Cognitively Impaired

- ADD ------------- Assessment of Discomfort in Dementia
- NOPPAIN-------- Non-communicative Patient’s Pain Assessment Instrument; nurse assistant screening tool
- PACSLAC -------- Pain Assessment Scale for Seniors with Severe Dementia
- PAINAD -------- Pain Assessment in Advanced Dementia Scale
- CNPI ------------ Checklist of Nonverbal Pain Indicators
### Checklist of Nonverbal Pain Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>With Movement</th>
<th>At Rest</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Expressions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moans, groans, grunts, cries, sighs, gasps, says ouch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocal Expressions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swears, says ouch, that hurts, stop, that's enough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial Expression:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wincles, grimace, furrowed brow, tight lips/jaw</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Braicing:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clutches, holds side rails, bed, table, or area of pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restlessness:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shifting position, hand movements, unable to keep still</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubbing:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touching, holding, rubbing or massaging affected area</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL:**

*Check each box if behavior observed at rest then with movement. Total each line (0-2)*

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### Pain Assessment in Advanced Dementia Scale (PAINAD)

Warden, Hurley, & Volicer, 2003

<table>
<thead>
<tr>
<th>Behavior</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent of vocalization</td>
<td>Normal</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cheyne-Stokes breathing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Repeated troubled calling out</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low-level speech with a negative or disapproving quality</td>
<td>Loud moaning or groaning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or inexpressive</td>
<td>Sad</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frightened Frown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>Tense</td>
<td>Fists clenched</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distressed pacing</td>
<td>Knees pulled up</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fidgeting</td>
<td>Pulling or pushing away</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Striking out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract, or reassure</td>
<td></td>
</tr>
</tbody>
</table>

**Total Score**
**Functional Pain Scale (FPS)**

- Designed to assess pain in older adults
- Subjective rating with objective findings of interference with function/activities scored 0–10
- May be used for older adults who are unable to self report their level of pain
- Appropriate if visual or mild to moderate cognitive impairment exists

Gloth, FM., et al., 2001

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**The Functional Pain Scale**

<table>
<thead>
<tr>
<th>0</th>
<th>2</th>
<th>4</th>
<th>6</th>
<th>8</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td>Activities unaffected</td>
<td>Prevents some active activities</td>
<td>Prevents all active, (not passive) activities</td>
<td>Prevents all passive activities</td>
<td>Incapacitated, unable to even speak due to pain</td>
</tr>
</tbody>
</table>

Active activities: usual activities or those requiring effort (turning, walking, etc)
Passive activities: talking on phone, watching TV, reading

Gloth FM, et al. 2001
Delirium

Remember that unrelieved pain in the elder may cause delirium. Try interventions and reassess delirium and pain behaviors.

Tools for Critically Ill/Unconscious

- **BPS: Behavioral Pain Scale.** Tested in intensive care, nonverbal adults, procedure pain.
- **CPOT: Critical-Care Pain Observation Tool.** Tested in intensive care, nonverbal adults, procedure pain. 0-8 scale.
- **NPAT: Nonverbal Pain Assessment Tool.** Tested in nonverbal & verbal adults in intensive care.
- **NVPS: Nonverbal Pain Scale.** Tested in nonverbal adults in cardiac post anesthesia care.
Hierarchy of Pain Assessment:
#4. Proxy Reporting of Pain

• Information of pain and behavior/activity changes from family members, parents, unlicensed caregivers, professional caregivers.

• May be able to identify subtle changes.

• Because proxies may overestimate or underestimate pain intensity, proxy assessments should be combined with other evidence when possible.

Revised FLACC: tested in children 4-19 yrs with mild to severe impairment, postop pain.

Individualized Numeric Rating Scale (INRS): tested in children 6-18 yrs with severe intellectual disability in acute care.

NCACP: NonCommunicating Adult Pain Checklist. Tested in adults, all levels of intellectual and developmental disabilities in residential/community settings.
Changes in heart rate, blood pressure, respiratory rate are not sensitive for discriminating pain from other sources of distress.

Correlations of vital sign changes with behaviors and self-reports of pain have been weak or absent.

Absence of a change in vital signs does not indicate absence of pain.


When in Doubt,

• Try an analgesic trial.
• Watch for changes in behavior and physiological indicators.
Comorbidities with Chronic/Persistent Pain

Psychiatric and Personality Issues:
• Up to half of all patients with chronic pain can have comorbid psychiatric condition
• Major depression thought to affect 30-50%
• Anxiety disorders next most prevalent

Depression

- Depression frequently co-exists with persistent pain
- Crying, withdrawn, avoiding eye contact, not wanting to talk or participate in activities may reflect depressive states
- Cognitive impairment may complicate identifying and/or treating depression
Depression Assessment (cont’d)

- Assess
  - Ability to manage daily lives
  - Mood
  - Sleep patterns
  - Appetite changes
  - Weight changes
  - Changes in daily life or interest in activities
  - Increased irritability
  - Separation from close friends or possessions
  - Suicidal/homicidal thoughts

Assessing Depression

- Assessment tools
  - **Beck Depression Inventory (BDI)**: 21 items completed in <10 minutes by patient.
  - **Geriatric Depression (GDS)**: 30 items.
  - **Center for Epidemiological Studies Depression Scale**: 20 items <10 mins by patient.
  - **Cornell Scale for Depression in Dementia**: 19 items for caregiver to complete.
  - Simple question: “Do you often feel sad or depressed?” may screen as well GDS and save time.
Physical Examination

1. Local/regional pain focused examination
2. Generalized musculoskeletal and neurological examination
3. Attention to functional limitations

Physical Exam (cont’d)

- Location of pain
- Quality/character of pain
  - Recent changes
- Presence of rebound
- Effects of weight bearing
- Functional status
- Range of motion
- Trigger points
- Inflammation
- Associated sensory deficits
- Exacerbating factors
- History of trauma
- Referred component of pain
## Assessing Pain in the Presence of Substance Abuse and Mental Illness

- Prevalence of substance abuse: 22.2 million individuals (9.1%) were classified with substance dependence or abuse in 2005. (The National Survey on Drug Use and Health)
- 2002 study of computerized patient records of US Dept. of Veterans Affairs hospitals were reviewed for details of pain complaints and prescriptions provided. Study found 21% had documented substance abuse history and 40% had at least one psychiatric diagnosis.
- Implications of pain and substance abuse/mental illness:
  - Opioid requirements generally higher due to tolerance and lack of multi-modal approach.
  - Lack of treatment of substance abuse or mental illness will impair ability to adequately treat pain.

## Assessment and Screening Tools for Addiction and Pain

- Screening for risk of prescription opioid abuse
  - STAR– Screening Tool for Addiction Risk: brief, 14 yes/no questions
  - ORT– Opioid Risk Tool
  - PMQ– Pain Medication Questionnaire: 26 item, 5 point Likert format reflecting attitudes and aberrant behaviors
  - LDQ–Leeds Dependence Questionnaire: items can decipher between taking prescription opioids to manage pain vs. maintaining an addiction
  - D.I.R.E. Clinician-rated scale with higher scores predicting better chance of opioid treatment efficacy and compliance.
D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

| Diagnosis          | 1 = Benign  
|                   | 2 = Slowly progressive condition  
|                   | 3 = Advanced condition concordant with severe pain with objective findings.  

| Intractability    | 1 = Few therapies have been tried and the patient takes a passive role  
|                   | 2 = Most customary treatments have been tried but the patient is not fully engaged  
|                   | 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.  

| Risks             | Psychological 1 = Serious personality dysfunction or mental illness.  
|                   | 2 = Personality or mental health interferes moderately.  
|                   | 3 = No significant personality dysfunction  

| Chemical health   | 1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse.  
|                   | 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission.  
|                   | 3 = No CD history. Not drug-focused or chemically reliant.  

| Reliability       | 1 = History of numerous problems: medication misuse, missed appointments, rarely follows through.  
|                   | 2 = Occasional difficulties with compliance, but gen. reliable.  
|                   | 3 = Highly reliable patient with meds, appts & treatment.  

| Social Support    | 1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles.  
|                   | 2 = Reduction in some relationships and life roles.  
|                   | 3 = Supportive family/close relationships. Involved in work or school and no social isolation.  

| Efficacy score    | 1 = Poor function or min. pain relief despite moderate to high doses.  
|                   | 2 = Mod. benefit with function improved in a number of ways.  
|                   | 3 = Good improvement in pain and function and quality of life with stable doses over time.  

Score 7-13: Not a suitable candidate for long-term opioid analgesia  
Score 14-21: May be a candidate for long-term opioid analgesia
State Programs for Prescription Monitoring.

- Differs from state to state.
- Minnesota’s program through Board of Pharmacy
- Report can assist in identifying individuals who are obtaining prescriptions from multiple providers, and pharmacies.
- Provides another tool in the discussion with patients about either undertreated pain, or prescription substance abuse.

Goals

- Identify individual patient goal.
  - Use assessment tools
  - Use functional status
  - Use patient preferences
  - Be realistic
- Measure effect of therapy against the goal
  - Were goals attained?
  - May need to be progressive goals
- With substance abuse disorder
  - Pain goals
  - CD treatment
  - Support sobriety, prevent relapse

American Society for Pain Management Nursing
Establish a Procedure for Pain Assessment

- Dependent upon specific health care setting
  - Tools/scales pertinent to populations.
- Reassess regularly:
  - With each new pain report, after interventions to treat pain
- Communicate across care providers and care settings
  - Ensure patient safety, continuity of care, and better outcomes.

Herr et al., 2006
References


Thank you for attending. You will be receiving an evaluation form via email. Please provide feedback!

Future sessions:
- Safety Monitoring of Prescription Opioids
- Risks and Benefits of Opioids in the Management of Persistent Pain
- Managing Chronic Pain in the Patient with Addictive Disorder
- The Role of the Advanced Practice Nursing in Pain Management

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