

Literature review of pain assessment tools



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Introduction

This essay will identify the issue of poorly addressed acute pain in hospitalized patients and critically compare and discusses a range of pain assessment tools referring to contemporary research literature and practice guidelines for patients who are able to self describe their pain and who are unable to self describe their pain due to verbal communication barriers, critical illness or delirium/dementia.

Main Body

According to the International Association for the Study of Pain, pain is an unpleasant sensory and emotional experience arising from actual or potential tissue damage (1). Clinically, “ Pain is whatever the experiencing person says it is, existing whenever he/she says it does” (McCaffery, 1968). The temporal profile classification is most commonly used to classify pain. This broad classification of pain duration is often used to better understand the biopsychosocial aspects that may be important when conducting assessment and treatment. For example, many times chronic pain is a result of unresolved acute pain episodes, resulting in accumulative biopsychosocial effects such as prolonged physical reconditioning, anxiety, and stress. It is obvious that this type of time categorization information can be extremely helpful in directing specific treatment approaches to the type of pain that is being evaluated (Gatchel & Oordt, 2003).

Acute pain is usually indicative of tissue damage and is characterized by momentary intense noxious sensations (i. e., nociception). It serves as an important biological signal of potential tissue/ physical harm. Some anxiety

may initially be precipitated, but prolonged physical and emotional distress usually is not. Indeed, anxiety, if mild, can be quite adaptive in that it stimulates behaviors needed for recovery, such as the seeking of medical attention, rest, and removal from the potentially harmful situation. As the nociception decreases, acute pain usually subsides. Unlike acute pain, chronic pain persists. Chronic pain is traditionally defined as pain that lasts 6 months or longer, well past the normal healing period one would expect for its protective biological function. Arthritis, back injuries, and cancer can produce chronic-pain syndromes and, as the pain persists, it is often accompanied by emotional distress, such as depression, anger, and frustration. Such pain can also often significantly interfere with activities of daily living. There is much more health care utilization in an attempt to find some relief from the pain symptoms, and the pain has a tendency to become a preoccupation of an individual's everyday living.

According to Buckley (2000) nurses are the primary group of health care professionals responsible for the ongoing assessment and monitoring of patients to ensure that pain is effectively and appropriately managed and that patients and families are informed of the consequences of acute pain. Assessment of pain can be a simple and straightforward task when dealing with acute pain and pain as a symptom of trauma or disease. Assessment of location and intensity of pain often suffices in clinical practice. However, other important aspects of acute pain, in addition to pain intensity at rest, need to be defined and measured when clinical trials of acute pain treatment are planned. If not, meaningless data and false conclusions may result. The 5 key components: Words, Intensity, Location, Duration,

Aggravating factors pain assessment are incorporated into the process.

Objective data are collected by using one of the pain assessment tools which are specific to special types of pain. The main issues in choosing the tool are its reliability and its validity. Moreover, the tool must be clear and, therefore, easily understood by the client, and require little effort from the client and the nurse.

According to Husband (2001) to measure the pain severity or intensity, several scales can be used such as a numeric rating scale (NRS), the visual analog scale (VAS), observation scales with indicators of pain, and even creative depictions of pain intensity with scale using a pain thermometer. The numeric rating scale allows patients to rate their pain on an 11-point scale of 0 (no pain) to 10 (worst pain imaginable). The majority of patients, even older adults can use this scale. The thermometer scale may be useful in the elderly, according to Rakel and Herr (2004). It shows a picture of a thermometer arranged on a background with a vertical word scale. Finally, categorical scales use verbal descriptors to quantify the level of pain and those scales have been validated and are considered to be reliable.

Chronic pain has a major impact on physical, emotional, and cognitive function, on social and family life, and on the ability to work and secure an income. Meaningful assessment of long-lasting pain is therefore a more demanding task than assessing acute pain. This is true both in clinical practice and when conducting trials of management of long-lasting pain. A comprehensive assessment of any chronic complex pain condition requires documenting (i) pain history, (ii) physical examination, and (iii) specific diagnostic tests. Chronic pain assessment tools are the Brief Pain Inventory

(BPI), which assesses pain severity and the degree of interference with function, using 0 – 10 NRS, and the McGill Pain Questionnaire (MPQ) and the short-form MPQ (SF-MPQ) evaluate sensory, affective–emotional, evaluative, and temporal aspects of the patient’s pain condition.

Pain assessment in older adults can be challenging and very difficult in some situations (Rakel & Herr, 2004). When the patient cannot report his/her subjective pain experience, proxy measurements of pain must be used, such as pain behaviours and reactions that may indicate that the person is suffering painful experiences. Besides communication difficulties caused by language problems, patients in the extremes of age, and critically ill patients in the intensive care setting, are common assessment problems. Older patients may prefer to use alternate means to express their pain through the use of word descriptors that best characterize the pain, such as “aching,” “hurting,” and “soreness” (Herr & Garand, 2001).

Significant challenges occur when assessing patients who are unable to communicate verbally, in writing, or by gestures, or when they are cognitively impaired.

Pain assessment should be ongoing at regular intervals, individualised and documented clearly to facilitate treatment and communication among health care clinicians.

Conclusion

In conclusion, adequate assessment of pain, using validated tools appropriate to the population or individual, is an essential prerequisite of

successful pain management. It has been shown in many countries that inadequate pain assessment is common, with resultant failings in management of pain. Inadequate pain control can prolong the recovery period, increase length of stay, and increase overall health care costs (Shang & Gan, 2003) Only by regularly assessing and measuring pain, as routinely as the other vital signs, can we hope to make pain visible enough to those caring for patients and thus improve management. This is especially true for the patients that anaesthetists care for every day, those with acute pain after surgery, trauma, and in the intensive care unit.