Pain is a component of up to 78% of ED presenting complaints yet most ED physicians have had minimal training related to pain recognition, assessment and management. Adequate pain assessment is complex and requires time to determine the patient’s past pain and medication history, current pain history, and pain intensity. ED providers are under pressure to recognize and treat pain while also dealing with overcrowding, a vast array of patient complaints, and concerns over opioid addiction and over prescribing. This course will review critical components of a rapid ED pain assessment, the current status of pain scales in the ED, electronic medical record documentation of pain and current literature.
Disclosures

- Phyllis Hendry, MD, FACEP, FAAP (Principal Investigator)
- Sophia Sheikh, MD, FACEP (Sub-Investigator)

- Pain Assessment and Management Initiative (PAMI)
- Funded by Florida Medical Malpractice Joint Underwriting Association, Alvin E. Smith Safety of Health Care Services Grant: 2014-2018
Learning Objectives

- Describe various pain assessment tools currently in the literature and pros/cons to using these tools in the ED setting;
- Discuss barriers to utilizing pain assessment tools and ways to overcome those barriers;
- List advantages to implementing a common pain assessment tool in the ED among the entire ED health care team; and
- Discuss evidence and controversy behind pain and patient satisfaction scores.
Pain as of August 2016

- Total upheaval in the world of pain management
  - New research regarding the neurobiological complexity of pain and long term consequences of untreated acute pain.

- Opioid epidemic has everyone pointing fingers and outcry for reducing opioids
  - CDC, The Joint Commission, Advocacy Groups
  - “Blame Game” among specialties
  - “Throwing out the baby with the bath water”

- Increase in ED based pain management research
Background, Barriers, and Challenges in the Emergency Department Management of Pain
Pain in the ED: Background and Barriers

- Pain is often the main reason why patients come to the ED
- Care in the ED often adds to a patient’s pain
- Pain can be a barrier to communication
- Overall error prone environment
Pain in the ED: Background and Barriers

- Patient credibility and provider biases
  - Unique population of patients with increased incidence of mental illness, substance abuse and co-morbidities leading to bias
  - Limited means or time to verify patient’s history
  - Drug-seekers vs drug-diverters vs legitimate pain
Pain in the ED: Background and Barriers

- Need to balance analgesia and sedation with adverse effects, especially at the extremes of age and with comorbidities
- Pain cannot be treated if it cannot be recognized and assessed
- 1-10 scale not very helpful
- Limited formal education
Pain in the ED: Background and Barriers

- Pain needs to be addressed within a reasonable period, yet...
  - Under pressure to rapidly disposition patients we don’t know
  - Difficult to differentiate between pain and anxiety
  - Lack of standardized assessment, reassessment and management tools especially for pediatric, non-English speaking, nonverbal, elderly or cognitively impaired patients
  - No RAPID pain evaluation tools for ED or EMS
Trying to Balance Pain Management While......

- Dealing with opioid crisis and pressure to decrease readmissions and triage to discharge times

- Working in crowded high risk environment
Assessment
Many Patients Do Not Receive “Adequate” Pain Assessments by EMS or in the ED

How can we appropriately treat pain if we don’t assess it?

- Studies:
  - Only 40-50% of trauma patients received pain assessments and analgesics
  - 34% of elderly patients with hip fracture had no pain assessment documented
Why the Lack of ED Assessment?

- Numbers don’t reflect the whole story . . .
- Acuity and clinical condition may explain lack of assessments- altered/head injured, intubated, inebriated, unstable
  - Patients are less likely to be assessed for pain as injury severity increases.
  - Physiologically unstable patients are least likely to receive a standardized pain assessment and to receive ED opioids.

Spilman 2016
Why the Lack of ED Assessment?

- Most EDs use a NRS to assess pain which requires an alert and oriented patient.

- Unfamiliarity with other pain scales or lack of time for more complex scales

- Patient acuity or condition may not allow for a full assessment

- Assessment tools for intoxicated or impaired patients lacking
Patient and Provider Attitudes Influencing Pain Assessment
Hypotheses for Inadequate Assessment or Under-estimation of Pain

1. Preference for signs over symptoms—physician ability to detect patient deception poor; correctly identified actors only 10% of the time.

2. Failure to recognize ED practices that themselves worsen pain by increasing patients’ anxiety and fear.

3. Belief by some practitioners that pain is proportional to tissue damage—don’t appreciate role of individuating factors.

Hypotheses for Inadequate Assessment or Under-estimation of Pain

4. Social distances between practitioners and some patient subpopulations can impair pain assessment and management.

5. Practitioners suspect patients of drug seeking and consequently of fabricating or exaggerating their pain leading to practice of defensive medicine.

Mandated Pain Assessments and Patient Satisfaction Scores
“Intent of the ‘pain as the fifth vital sign’ campaign was to encourage doctors and nurses to listen to their patients and assess their pain. No intent to have everyone take an opioid.”

“In describing pain as the fifth vital sign, the message is that pain assessment is a priority.”

-- James N. Campbell 2016
**Unintended Consequences of the 5th Vital Sign**

- Renewed focus on pain assessment but reliance on uni-dimensional assessment tools leading to:
  - Opioid over-prescribing
  - Adverse events
  - Over-sedation
  - Increased from 11 to 24.5 (P < 0.001) per 1,000,000 inpatient hospital days following use of an acute pain treatment algorithm guided by a numerical pain rating

- Mandated pain assessments not shown to improve pain management or patient outcomes
Patient Satisfaction Scores

- 71% of ED physicians perceived pressure to prescribe opioids to avoid administrative and regulatory criticism

- 98% felt patient satisfaction scores were too highly emphasized by reimbursement entities as a means of performance evaluation

- Rising patient volumes and changes in the healthcare climate were reported factors impacting management of patients exhibiting "drug seeking" behavior.
Patient Satisfaction Scores

- Press Ganey patient satisfaction scores in the ED not associated with analgesics or opioid administration in the ED.
- Very controversial subject
- Changes predicted for HCAHPS (the Hospital Consumer Assessment of Healthcare Providers and Systems) score evaluation and usage
Role of Electronic Medical Record (EMR) in Pain: Has it Improved Pain Assessment?

- Incorporation of pain scales into EMRs improved documentation of pain scores
  - Mixed results for improved administration of analgesics and reduction in time to administration of analgesics
  - Focuses on *pain intensity*, not pain *assessment*

- Pain order sets based on pain severity
  - Does not allow for individualization
  - Risk for adverse events like over-sedation

“Give patients a voice, not a number” - University of Utah
Role of EMR in ED Pain Assessment

- Kaplan et al. 2008
  - Mandatory recording of pediatric pain scores in EMR raised documentation from 7% to 38% but no improvement in administration or decrease in time to treatment

- No recent ED studies but Urban et al. 2015 found computerized provider order entry allowed for faster postoperative analgesia, decreased pain scores, and required less medication compared to paper-entry
Pain Assessment and Discharge Planning

- Pain assessment scores and tools are needed to manage ongoing pain in the ED and to determine fitness for discharge or need for admission.

- Appropriate discharge planning:
  - reduces return visits
  - expedites return to normal activities and work
  - helps reduce risk of acute pain progressing to chronic pain
Unidimensional Tools for Pain Assessment: Pain Scales
Pain Assessment Scales

- Populations
  - Adult
  - Pediatric
  - Special Situations
- No pain scale validated for ED or pre-hospital use
- Most pediatric scales originally developed to measure procedural-related pain.

- General categories:
  - Observational-behavioral scales require provider to assess patient on multiple behaviors and rank them.
  - Self-report scales include selection of a face or color or number to represent pain.
# Examples of Pain Scales

<table>
<thead>
<tr>
<th>Pain Scales*</th>
<th>Verbal, Alert and Oriented</th>
<th>Non-verbal, GCS &lt;15 or Cognitive Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. <strong>Verbal Numeric Scale (VNS)/Numeric Rating Scale (NRS)</strong></td>
<td>1. <strong>Adult Non-Verbal Pain Scale (NVPS)</strong></td>
</tr>
<tr>
<td></td>
<td>2. <strong>Visual Analogue Scale (VAS)</strong></td>
<td>2. <strong>Assessment of Discomfort in Dementia (ADD)</strong></td>
</tr>
<tr>
<td></td>
<td>3. <strong>Defense and Veterans Pain Rating Scale (DVPRS)</strong></td>
<td>3. <strong>Behavioral Pain Scale (BPS)</strong></td>
</tr>
<tr>
<td></td>
<td>4. <strong>Critical-Care Observation Tool (CPOT)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3 yo and older</strong></td>
<td>1. <strong>Wong Baker Faces</strong></td>
<td>1. <strong>Neonatal Infant Pain Scale (NIPS)</strong></td>
</tr>
<tr>
<td></td>
<td>2. <strong>Oucher (3-12yrs)</strong></td>
<td>2. <strong>Neonatal Pain Assessment and Sedation Scale (N-PASS)</strong></td>
</tr>
<tr>
<td></td>
<td>3. <strong>Numerical Rating Scale (NRS)</strong></td>
<td>3. <strong>Neonatal Facial Coding System (NFCS)</strong></td>
</tr>
<tr>
<td></td>
<td>(7-11yrs)</td>
<td>4. <strong>CRIES</strong></td>
</tr>
<tr>
<td><strong>8 yo and older</strong></td>
<td>1. <strong>Visual Analogue Scale (VAS)</strong></td>
<td>1. <strong>Revised Faces, Legs, Activity, Cry, and Consolability (r-FLACC)</strong></td>
</tr>
<tr>
<td></td>
<td>2. <strong>Verbal Numeric Scale (VNS)/Numeric Rating Scale (NRS)</strong></td>
<td>2. <strong>Non Communicating Children’s Pain Checklist (NCCPC-R)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. <strong>Children’s Hospital of Eastern Ontario Pain Scale (CHEOPS) (ages 1-7)</strong></td>
</tr>
</tbody>
</table>
What do the numbers mean?

Pain = 3

Pain = 10
The Nature of Pain

- Pain - complex, multifactorial, emotional, and subjective sensation
- Pain Scales - unidimensional, single digit tool, representing a snapshot of the magnitude of pain at a specific time
Factors Affecting Assessment—Personalized Approach

- Age, gender, ethnicity
- Socioeconomic and psychiatric factors
- Culture and religion
- Genetics
- Previous experiences
- Patient perceptions
  - Patient expectations and perceived care by the treating provider(s)
Pain Assessment Scales

- Validity?
- “Does this instrument measure what it is supposed to measure?”
  - Picture scales good in populations with limited literacy (peds), males uncomfortable with scales depicting severe pain with tears
  - Verbal rating scales showed limited precision in low literacy and cognitively impaired pts.
  - Lack of supporting ED data

Visual Analog Scale (VAS) Limitations

  - N = 1999, prospective observational study
  - Change in VAS did not correlate with change in pain intensity, as measured by verbal descriptor scale (VDS)
  - Change in VAS may not be a valid indicator of pain relief
Visual Analog Scale (VAS) Limitations

  - No single cutoff on the pain scale could reliably predict a patient’s desire for medication

- Lee et al. Acad Emerg Med 2003
  - A change of 30 (0-100) on the VAS is the minimal clinically important difference, based on adequate pain control as specified by the patient
Numeric Rating Scale (NRS) Limitations and Issues

- NRS pain scale validated research tool to assess change in pain in cancer patients
- The NRS is sensitive to the short-term changes in pain intensity associated with emergent care
  - NRS preferred by patients, higher completion rates than VAS
Patients and staff often have different subjective definitions of the 0-10 scale.
  - Leads to inaccurate measurement of pain
If the reporting of pain is inaccurate, it can only be expected that the treatment will be equally ineffective.
FLACC Scale Limitations and Issues

- Cannot be generalized to older children, adolescents, or adult patients
- Limited utility in cognitively impaired pediatric patients

<table>
<thead>
<tr>
<th>FLACC Scale</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Face</td>
<td>No particular expression or smile.</td>
<td>Frequent to constant frown, clenched jaw, quivering chin.</td>
</tr>
<tr>
<td>2</td>
<td>Legs</td>
<td>Normal position or relaxed.</td>
<td>Kicking, or legs drawn up.</td>
</tr>
<tr>
<td>3</td>
<td>Activity</td>
<td>Lying quietly, normal position, moves easily.</td>
<td>Arched, rigid or jerking.</td>
</tr>
<tr>
<td>4</td>
<td>Cry</td>
<td>No crying (awake or asleep).</td>
<td>Crying steadily, screams or sobs, frequent complaints.</td>
</tr>
<tr>
<td>5</td>
<td>Consolability</td>
<td>Content, relaxed.</td>
<td>Difficult to console or comfort.</td>
</tr>
</tbody>
</table>
Scale with Color, Numerical, Descriptive and Visual Components—Old Version

Defense and Veterans Pain Rating Scale*

1. No pain
2. Hardly notice pain
3. Notice pain, does not interfere with activities
4. Sometimes distracts me
5. Distracts me, can do usual activities
6. Interrupts some activities
7. Hard to ignore, avoids usual activities
8. Focus of attention, prevents doing daily activities
9. Awful, hard to do anything
10. Can’t bear the pain, unable to do anything
11. As bad as it could be, nothing else matters

*M The PMTF recommended a Department of Defense and VHA Pain Assessment Tool to improve actionable information for patient encounters across Military Treatment Facilities. (Line of Action 1, Standards and System Improvements)
Defense and Veterans Pain Rating Scale (DVPRS) v 2.0

- New pain faces - excellent interrater agreement
- Excellent correlation to Brief Pain Inventory-Short Form
Defense and Veterans Pain Rating Scale (DVPRS) v 2.0

- Assesses subjective + objective (functionality) pain experience

- Color coding system (green, yellow, red) has specific implications for prioritizing patients in need of prompt and effective pain care

- Pain intensity scale has utility for identifying injured service members most at risk for early central sensitization from severe unrelieved pain

- Promising for the ED population but......
Defense and Veterans Pain Rating Scale (DVPRS) v 2.0

- Study population - military
  - 81.4% male, 62.9% Caucasian, 60.3% married, 42% associate’s degree or higher
  - 72% active duty military
  - 36% Acute post-op pain
  - 32% chronic non-cancer pain
  - 29% neuropathic pain

- Demographics not reflective of most ED populations
Factors Associated with Higher Pain Scores

- Younger age
- Female gender
- African American race
- Medicaid insurance
- Multiple ED visits in the past year
- ED diagnoses of sickle cell pain, back/neck/shoulder pain, and headache
Pain Score 8, Now What?

- What should we do with a pain score?
  - How do we compare studies using different pain scores?
  - Treat if the number is high? And with what?
  - Not treat if the number is low?
  - What number is unacceptable for discharge?
  - Do we believe the score?
Pain score 8, Now What?

- What change in the pain score means a patient can go home?
  - Decision point: admit or discharge home

- What changes indicate “successful” treatment?
Pain Reduction Clinical Outcomes

- Minimal clinically significant difference (MCSD) in pain severity - 1.5 on 11 point NRS or a proportional change of 25%.

- Change of at least 2 on a 0–10 pain intensity scale, or 33% pain intensity difference reported to represent patient-determined clinically important relief.

- Change of 30 (0-100) on VAS is minimal clinically important difference, based on adequate pain control per patient.
What Existing Pain Scales are Missing

- None designed specifically for ED setting
- Scales used by majority of EDs are not designed for chronic pain
- Lack of context (what does 8 out of 10 really mean?)
- Most scales used in the ED don’t assess functionality
Other Assessment Tools:
Moving away from Numbers

PMPs
Functionality and Quality of Life
Substance Abuse, Opioid Risk Tools
Mental Health Assessment
Prescription Monitoring Programs--
Theoretically a Helpful Assessment Tool

- No integration with EMR;
- Difficult to find;
- Invalid password;
- Site maintenance;
- Too many clicks;
- Delay in time rx filled to when it shows up in system;
- If pharmacy inputs data wrong then nothing will show—missing rx;
- Multiple records for same pt;
- Doesn’t provide interpretation—how many MME pt takes?
- How many overlapping rx?
- Doesn’t list type of dr. writing rx or their office/location/contact info;
- Doesn’t take into account non-medical use;
- Doesn’t tell you abuse hx;
- Doesn’t tell you if pt has pain contract

So Why Don’t We Always Use Them?
PMPs and Opioid Overdose Risks- Assessment

- Predictors for opioid overdose:
  - Number of days receiving more than 100 MME
  - Number of ‘trinity’ days (opioid, benzodiazepines, muscle relaxer)
  - Number of prescriptions
  - Multiple drug days
  - Early refills
PDMPs and Opioid Overdose Risks - Assessment

- Predictors for high-risk behaviors:
  - $\geq 4$ opioid prescriptions  AND
  - $\geq 4$ providers for schedule II-V medications in the past 12 months
Physical Functionality & Quality of Life Scales

- Brief Pain Inventory
- Physical Functional Ability Questionnaire
- Palliative Performance Scale
  - (Karnofsky Scale)
- Oswestry Low Back Disability Index
- American Pain Foundation Scale
- EQ5D-5L
Physical Functionality & Quality of Life Scales

- These scales are difficult to administer in ED setting due to length and time but provide important assessment components.
- Most ED physicians are not familiar with these scales.
- What about re-assessments?
Substance Abuse Tools

- Webster's Opioid Risk Tool (ORT)
- Screener and Opioid Assessment for Patients in Pain (SOAPP®)
- Current Opioid Misuse Measure (COMMTM)
- Prescription Drug Use Questionnaire (PDUQ)
- Screening Tool for Addiction Risk (STAR)
- Screening Instrument for Substance Abuse Potential (SISAP)
- Pain Medicine Questionnaire (PMQ)
Substance Abuse Screening in the ED

- Weiner et al. 2016
  - 32.9% of ED patients considered for discharge with an opioid scored “at-risk” on Screener and Opioid Assessment for Patients with Pain (SOAPP-R)

- Broderick et al 2015
  - Patients were asked if used street drugs or marijuana in the past 3 months
  - 40% sensitivity—missed 60% of individuals testing positive on the Alcohol, Smoking, and Substance Involvement Screening Tool (ASSIST)
  - 72% sensitivity for marijuana use
Mental Health Tools

- SIGECAPS
- Beck Depression Inventory-Fast Screen (BDI-FS)
- The Mental Health Triage Scale (MHTS)
- Patient Health Questionnaire
Catastrophizing and Anxiety scales

Kapoor et al 2016

- 100 patients presenting to ED with acute pain

- Pain Catastrophizing Scale (PCS), and the State-Trait Anxiety Inventory-State Subscale (STAI-S).

- Pain intensity was significantly and positively associated with pain catastrophizing and anxiety
Catastrophizing and Anxiety scales

Kapoor et al 2016

- Need to consider the psychological distress from anxiety and pain catastrophizing of patients presenting to EDs with acute pain.

- “Brief behavioral interventions in conjunction with pharmacological interventions could improve outcomes”. 
Does One Perfect ED Assessment Tool Exist?
Does one perfect assessment tool exist?

- An ideal pain assessment should include:
  - patient’s subjective experience +
  - functionality assessment +
  - pain catastrophizing and anxiety +
  - substance abuse and opioid-addiction risks +
  - PDMPs +
  - psychiatric conditions and comorbidities

RAPID???

And we still have to complete a history and physical exam!
OPQRST, SOCRATES and QISS TAPED

- Numerous questions
- Time constraining
- Beyond scope of this presentation
- Portions could be incorporated into model rapid pain assessment
<table>
<thead>
<tr>
<th>O: Onset (when did it start)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: Provocation or Palliation (what makes it better or worse)</td>
</tr>
<tr>
<td>Q: Quality (sharp, dull, crushing)</td>
</tr>
<tr>
<td>R: Region and Radiation</td>
</tr>
<tr>
<td>S: Severity (pain score)</td>
</tr>
<tr>
<td>T: Timing (type of onset, intermittent, constant)</td>
</tr>
<tr>
<td>AS: Associated Symptoms</td>
</tr>
<tr>
<td>PN: Pertinent Negatives</td>
</tr>
</tbody>
</table>

| Site - Where is the pain? Or the maximal site of the pain. |
| Onset - When did the pain start, and was it sudden or gradual? Include also whether if it is progressive or regressive. |
| Character - What is the pain like? An ache? Stabbing? |
| Radiation - Does the pain radiate anywhere? |
| Associations - Any other signs or symptoms associated with the pain? |
| Time course - Does the pain follow any pattern? |
| Exacerbating/Relieving factors - Does anything change the pain? |
| Severity - How bad is the pain? |

- **Quality**
- **Impact**
- **Site**
- **Severity**
- **Temporal**
- **Aggravating and alleviating**
- **Past response and preferences**
- **Expectations and goals**
- **Diagnostics and physical exam**
How would components of your assessment differ for the following cases?

- 80 YO with hip fracture after a mechanical fall
- 4 YO with lip laceration
- 35 YO with sickle cell disease and pain
- 19 YO with femur fracture after MVC
- 45 YO with chronic low back pain on a pain contract
- 55 YO with depression and fibromyalgia
Pain Assessment Toolbox: Proposed Components

1. Pain history and exam
2. Subjective- pain scales or scores
3. Functionality/disability
4. Chronic pain scales
5. Substance abuse tools
6. Opioid risk/abuse tools
7. PMPs
8. Catastrophizing scales
9. Anxiety scales
10. Mental health screening tools
Pain Assessment Algorithm in an Ideal World

Chronic Pain Grade Questionnaire
PMPs

Perform pain history and exam
Subjective pain assessment
Functional pain assessment

Is pain chronic?

At risk for substance abuse? Opioid abuse?

Signs of Pain
Catastrophizing? Anxiety?

PCS
STAI-S

Risk for depression?

Institute appropriate treatment; Monitor and reassess

ORT, CAGE-AID, SBIRT, DAST-10, PMPs

Risk for depression? Yes

SIGECAPS

Pain Assessment Toolbox
Components
1. Pain history and exam
2. Subjective- pain scales
3. Functionality/Disability
4. Chronic pain scales
5. Substance abuse tools
6. Opioids risk/abuse tools
7. PMPs
8. Catastrophizing scales
9. Anxiety scales
10. Mental health screening
Developing a Rapid Pain Assessment for the ED

- Consider the patient’s subjective pain assessment then adjust based on exam or patient behavior.

- Better approach is to ask how pain is affecting function?

- Assign value to a number- contextualize the score and change in score. (10/10 hang nail pain vs 10/10 fracture pain)

- Combine a qualitative scale + physician interpretation of the NRS along with other factors (allergies, PDMD, frequent visits, presenting injury/hx, level of tolerance, etc.)
Conclusions
What is Needed?

- Pain scales that are validated in the ED setting
  - Study of Defense and Veterans Pain Rating Scale (DVPRS) v 2.0 in ED
  - Need more than a number!

- Determine ways to assess a patient’s subjective and objective pain experience along with substance/opioid abuse risks

- Research and collaboration
  - CDS (clinical decision support) algorithm development: acute vs chronic, critical vs noncritical, risk factors and comorbidities, etc.
  - Screening tools
ED Palliative Care Screening Tool

General Information

Relation of person providing information (circle): Patient, parent, child, sibling, other: ________________

Patient Label: ________________

Patient Age: ________________ Date of ED Visit: ________________ Mode of Arrival: Car, EMS, Bus, Private, ALS, other: ________________

Arrived from: home, nursing home, another hospital, specialty hospital, shelter, other: ________________

Key Caregiver(s): Who helps take care of you/patient or do you take care of yourself? Self, Someone else: ________________

Name: ________________ Relation: ________________ Phone: ________________

What physician is taking care of most of your medical problems (Primary care and/or specialists): ________________

Do you make your own health care decisions? Yes, No: ________________

If you were unable to make healthcare decisions, who would you select to make those choices? Name: ________________ Relation: ________________ Phone: ________________

Do you have any advanced directives such as a Living Will, Do Not Resuscitate or Allow Natural Death orders? Yes, No: ________________

If yes, which ones (circle all that apply): Living Will, Do Not Resuscitate, Natural Death: ________________

Language: Is English your primary language? Yes, No: ________________ If no, what is your primary language: ________________

REALM-R: Unable to complete: ________________ Unable to speak < 6 words: ________________ Realm-R Score: ________________

Disease State: Do you or the person you are caring for/represent have one or more of the following advanced illnesses or symptoms:

- Chronic Obstructive Pulmonary Disease (COPD) or other chronic lung disease? Y/N
- Congestive Heart Failure (CHF) or other chronic heart disease? Y/N
- Dementia, stroke, failure to thrive or Alzheimer's disease? Y/N
- Cancer? Metastatic, recurrent? Y/N
- Kidney Failure Y/N
- Liver Failure Y/N
- Other conditions such as HIV or AIDS, Parkinson's or ALS? Other: ________________

- Oxygen-dependent: Y/N
- SO2 at rest: Y/N
- Bed bound more than 3 months? Y/N
- Weakness: Y/N
- Unable to care for self: Y/N
- Nausea: Y/N
- Weakness: Y/N
- Unable to care for self: Y/N
- Distress: Y/N
- Shortness of breath: Y/N

Is your ED visit today because of (related to): Check all that apply:

- Difficulty to control physical symptoms (nausea, shortness of breath, fatigue, etc.): ________________
- Difficulty to manage or increasing emotional symptoms: ________________
- Uncontrolled pain: ________________
- Caregiver burden or unavailable: ________________
- Need for equipment: ________________
- Need for medications: ________________

Pain and Symptom Assessment: Circle the number that best describes your symptoms during the past week:

- Pain: 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
- Tiredness: 0 1 2 3 4 5 6 7 8 9 10 Worst possible tiredness
- Anxiety or worry: 0 1 2 3 4 5 6 7 8 9 10 Worst possible anxiety
- Nausea: 0 1 2 3 4 5 6 7 8 9 10 Worst possible nausea
- Weakness: 0 1 2 3 4 5 6 7 8 9 10 Worst possible weakness
- Dryness: 0 1 2 3 4 5 6 7 8 9 10 Worst possible dryness
- Distress: 0 1 2 3 4 5 6 7 8 9 10 Worst distress
- Shortness of breath: 0 1 2 3 4 5 6 7 8 9 10 Worst possible shortness of breath

Comments and Notes: ________________
Communicate with the ED patient!

- Patients getting adequate pain relief may not want to report.
  - Fear provider may decrease pain medications or efforts to identify source of pain (Carter 2016)
  - 49% did not want analgesics (pain score 6.4) and 19% of these patients received them anyway (Singer 2008)

- Talk to patients and find out if pain is tolerable or intolerable, identify a common goal

- Education on need for accurate pain scores to assess treatment
  - Discuss reality of pain relief- pain scores of 0 are unrealistic
The Bottom Line

- Pain is multifactorial thus assessment should reflect this

- Tailor assessment to the patient
  - How you assess the 4 yo with a laceration will differ from the 45 yo with chronic back pain on a pain contract

- Recognize the role psychosocial factors play in pain assessment

- Don’t forget about reassessments
  - Assess functional status with each re-evaluation
The Bottom Line

- Finally…..
  
  - Know your limitations and those of your work environment
  - Consider patient acuity and reasonable goals of care
Questions

Thank you!

Please share your ideas on how to perform a rapid ED pain assessment.

Email: Sophia.Sheikh@jax.ufl.edu or Phyllis.Hendry@jax.ufl.edu
Phone: 904-244-4986
Website: http://pami.emergency.med.jax.ufl.edu
References

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