Palliative Care Consultant GEMS™

Pain Assessment

Pain is a common symptom at end of life with prevalence estimated at 51%. Palliation of pain, using non-pharmacological and/or pharmacological interventions, is one goal of hospice care. Selection of appropriate non-pharmacological or pharmacological interventions is dependent on assessment. This guide serves as a foundation for the assessment of pain experienced at the end of life.

Step 1
Complete general patient assessment

Vital Signs	Support System	Prognostic Assessment	Medications
▪ Body temperature ▪ Pulse rate, rhythm, and strength ▪ Respiratory rate and rhythm ▪ Blood pressure ▪ Oxygen saturation	▪ Current residence ▪ Residence concerns ▪ Primary caregiver ▪ Frequency of caregiver assistance ▪ Caregiver concerns	▪ PPS or Karnofsky Score ▪ Ability to perform ADLs ▪ Oral intake ▪ Swallowing status ▪ Level of consciousness	▪ Current medication list ▪ New medications ▪ Discontinued medications ▪ Allergies, medication interactions, duplication of therapy, clinical concerns

Step 2
Complete a pain assessment using BPQRSTUV (communicative patients) or PAIN-AD (patients with advanced dementia), or IASP Faces Pain Scale – Revised (non-verbal patients)

Communicative Patients: BPQRSTUV[1]	
Baseline	▪ What is normal for the individual?
Precipitating and Alleviating Factors	▪ What brings the pain on? Has the patient fallen recently? Does the patient have any wounds? ▪ What makes the pain better? What makes the pain worse? ▪ Is there evidence to suggest the pain is due to disease progression, such as metastasis?
Quality	▪ How would you describe the pain? ▪ Has the quality of the pain changed over time?
Region / Radiation	▪ Where is the pain located? Has the location of the pain changed over time? ▪ Does the pain radiate or spread to other areas of the body?
Severity	▪ On a 0 – 10 scale, with 0 being none and 10 being the worst possible, how would you rate your pain? ▪ Is the pain getting better, worse, or staying the same? ▪ What level of pain is acceptable or tolerable? Is the goal to reduce severity or to improve function? ▪ Are there any other symptoms associated with the pain? What is the severity of these symptoms?
Time / Temporal	▪ When did the pain begin? How often have you experienced the pain in the last 24 hours? ▪ Is the pain worse at a certain time of day or does it change throughout the day? Does the pain wake you up?
Utilization	▪ What non-pharmacological and/or pharmacological treatments are currently being used (including doses)? ▪ What non-pharmacological and/or pharmacological treatments or dose adjustments have been trialed in the past? ▪ What is the response to these interventions – effective or ineffective?
Values	▪ How is the pain impacting your quality of life? ▪ What activities would you like to do if the pain was not problematic?

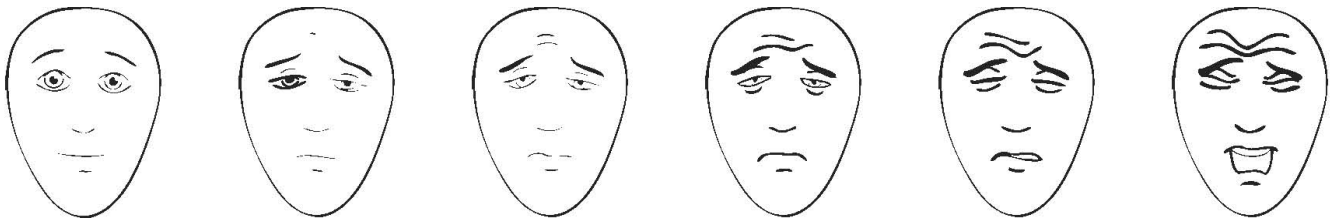
druginformation@optum.com

Advanced Dementia: PAIN-AD[2]

Items*	0	1	2	Score
Breathing independent of vocalization	▪ Normal	▪ Occasional labored breathing ▪ Short period of hyperventilation	▪ Noisy labored breathing ▪ Long periods of hyperventilation ▪ Cheyne-Stokes respiration	
Negative vocalization	▪ None	▪ Occasional moan or groan ▪ Low-level speech with a negative or disapproving quality	▪ Repeated troubled calling out ▪ Loud moaning or groaning ▪ Crying	
Facial expression	▪ Smiling or inexpressive	▪ Sad, frightened, frown	▪ Facial grimacing	
Body language	▪ Relaxed	▪ Tense ▪ Distressed pacing ▪ Fidgeting	▪ Rigid ▪ Fists clenched, striking out ▪ Knees pulled up ▪ Pulling or pushing away	
Consolability	▪ No need to console	▪ Distracted or reassured by voice or touch	▪ Unable to console, distract. or reassure	
			Total**	

*Five-item observational tool
**Total scores range from 0-10, with a higher score indicating more severe pain (0=no pain, 10=severe pain)
Complete instructions and explanations of the observational assessment process are available at http://www.amda.com/publications/caring/may2004/painad.cfm

Non-Verbal Patients: IASP Faces Pain Scale – Revised[3]



0 **2** **4** **6** **8** **10**

*Score the chosen face **0**, **2**, **4**, **6**, **8**, or **10**, counting left to right, so "0" = "no pain" and "10" = "very much pain". Do not use words like "happy" or "sad".*

Complete instructions and explanations of the observational assessment process are available from IASP at https://www.iasp-pain.org/resources/faces-pain-scale-revised/

Step 3
Identify the type and origin of pain to guide appropriate pharmacological interventions

Take note! Some questions are directed to the patient or caregiver; other questions are directed to the clinician. Also, there may more than one cause of the pain – evaluate for all causes.

Identifying the Type and Origin of the Pain[4]

Ask: ▪ Does the patient describe the quality of pain as sharp, localized, aching, or throbbing? ▪ Can the patient point to the source of the pain? ▪ Did a recent fall contribute to the onset of the pain? ▪ Does the patient have a wound? ▪ Is there evidence of trauma? ▪ Does the patient have a history of degenerative joint disease? ▪ If the patient has cancer, is there evidence or history of bony metastasis or pathological fracture? ▪ Does the patient have a history of vertebral compression fractures? ▪ Does the patient have a history of cancer or known brain metastasis and complains of headache?	▪ If yes, suspect **nociceptive somatic pain** and the origin of pain is in the muscle, bone, or soft tissues. ▪ If no, evaluate for other pain types and origins.
Ask: ▪ Does the patient describe the quality of pain as dull, crampy, spasmic, nauseous, pressure, or squeezing? ▪ Is the pain poorly localized? ▪ Does the pain radiate away from the site of injury? ▪ Does the patient have any symptoms of a bowel obstruction, including abdominal pain, nausea, vomiting, constipation, obstipation, abdominal distention, hyperactive bowel sounds, or paradoxical diarrhea (leakage of stool around the impaction)? ▪ Is the patient experiencing bladder or rectal spasms? ▪ Is there evidence of ischemia or other organ damage?	▪ If yes, suspect **nociceptive visceral pain** and the origin of the pain is in a visceral organ, such as the heart, liver, pancreas, or small bowel. ▪ If no, evaluate for other pain types and origins.
Ask: ▪ Does the patient describe the pain as shooting, burning, tingling, or as pins and needles? ▪ Does the patient complain of lower extremity pain and has a history of diabetic neuropathy, diabetes mellitus, or paraneoplastic peripheral neuropathy? ▪ Is there evidence of ischemia to the lower extremities? Does the patient have a history of lower extremity arterial disease or peripheral vascular disease? ▪ If the patient describes the pain as pins and needs, does the patient have a history of neurological disease or a vertebral compression fracture? ▪ If the patient has cancer, is tumor growth contributing to the pain characteristics?	▪ If yes, suspect **neuropathic pain** is the cause of the agitation. ▪ If no, evaluate for other pain types and origins.

druginformation@optum.com

Step 4
Rule out opioid-induced neurotoxicity as the cause of the pain

- OIN is a term used to describe the neuropsychiatric symptoms that result from the use of opioids, especially opioids with active, toxic metabolites (e.g., morphine and hydromorphone).

Screening for Opioid Induced Neurotoxicity (OIN)[5]

Suspect OIN if "Yes" is the answer to one or more of the following questions:

- Does the patient have any predisposing factors for OIN, such as high opioid doses, prolonged opioid use, rapid opioid dose escalation, concurrent use of other psychoactive medications, underlying dementia or other cognitive impairment, dehydration, renal failure (or decreased urine output), advanced age, or a history of OIN?
- Has the dose of opioid been increased recently with minimal or no improvement in pain?
- Does the patient complain of pain generalized to the whole body?
- Does the patient complain of hyperalgesia (abnormal sensitivity to pain) or allodynia (pain from stimuli that are not normally painful)?
- Does the patient have signs or symptoms of delirium, including an acute change in the level of consciousness with fluctuations in status throughout the day; trouble directing, sustaining, or shifting attention; or a language impairment or problems naming?
- Is the patient experiencing hallucinations, seizures, or myoclonus (sudden, brief, involuntary muscle jerk caused by an abrupt muscle contraction)?

Step 5
Differentiate inappropriate opioid use versus poorly managed pain

Addiction Behaviors Checklist[6]

Addiction Behaviors – since last visit	**Yes, No, or NA***
▪ Patient used illicit drugs or evidences problem drinking*	
▪ Patient has hoarded meds	
▪ Patient used more narcotic than prescribed	
▪ Patient ran out of meds early	
▪ Patient has increased use of narcotics	
▪ Patient used analgesics PRN when prescription is for time contingent use	
▪ Patient received narcotics from more than one provider	
▪ Patient bought meds on the streets	
Addiction Behaviors – within current visit	**Yes, No, or NA***
▪ Patient appears sedated or confused (e.g., slurred speech, unresponsive)	
▪ Patient expresses worry about addiction	
▪ Patient expresses a strong preference for a specific type of analgesic or a specific route of administration	
▪ Patient expresses concern about future availability of narcotic	
▪ Patient reports worsened relationships with family	
▪ Patient misrepresents analgesic prescription or use	
▪ Patient indicates she or he ''needs'' or ''must have'' analgesic meds	
▪ Discussion of analgesic meds was the predominant issue of visit	
▪ Patient exhibits lack of interest in rehab or self-management	
▪ Patient reports minimal/inadequate relief from narcotic analgesic	
▪ Patient indicates difficulty with using medication agreement	
Other	**Yes, No, or NA***
▪ Significant others express concern over patient's use of analgesics	
ABC Score	

Score of ≥3 indicates possible inappropriate opioid use and should flag for further examination of specific signs of misuse and more careful patient monitoring (i.e., urine screening, pill counts, removal of opioid)
*NA: Not assessed

druginformation@optum.com

Step 6
Differentiate between existential suffering and physical pain

Screening for Existential Suffering[7]

Suspect existential suffering if "No" is the answer to the following question:

- Are you at peace?

If "No" is the answer, investigate existential suffering more by asking:

- What is keeping you from being at peace?
- What worries you most about your illness?
- Do you feel that no one understands what you are going through?
- Are you anxious about dying or an afterlife? Do you have concerns about separating from your loved ones?
- Do you regret past choices? Are you thinking about unresolved conflicts with yourself, a friend, or a family member?
- Do you feel like you have lost purpose? Do you question the meaning of your illness or suffering?
- Do you feel abandoned by or disconnected from your family or community or God?

Step 7
Determine if anxiety is a source of the pain or contributing to exacerbation of chronic pain

Identifying Anxiety as a Component of Pain[4]

Suspect anxiety is problematic if "Yes" is the answer to any of the following questions:

- Does the patient have a history of phobias or social phobia, generalized anxiety disorder, obsessive compulsive disorder, or post-traumatic stress disorder?
- Does the patient display behaviors that indicate anxiety, such as intense worry/dread, inability to concentrate, insomnia, nausea, or palpitations?

References

1. Chalkley AJ, Mulhall DJ. The PQRSTUV: The Personal Questionnaire Rapid Scaling Technique. Br J Clin Psychol. 1991;30(Pt 2):181-3.
2. Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. J Am Med Dir Assoc. 2003;4(1):9-15.
3. International Association for the Study of Pain (IASP). Faces pain scale – revised. September 11, 2014. Washington, DC; IASP, 2014. https://www.iasp-pain.org/resources/faces-pain-scale-revised/ Accessed June 27, 2023.
4. Grauer PA. Pain. In: Protus BM, Kimbrel JK, Grauer PA, eds. Palliative Care Consultant: Guidelines for Effective Management of Symptoms. 4th ed. Montgomery, AL: HospiScript, a Catamaran Company; 2015: 135-176
5. Kozlov M, Anderson MA, Sparbel K. Opioid-induced neurotoxicity in the hospice patient. J Hosp Palliat Nurs 2011;13(5):341-346.
6. SM Wu, P Compton, R Bolus, et al. The addiction behaviors checklist: validation of a new clinician-based measure of inappropriate opioid use in chronic pain. J Pain Symptom Manage. 2006; 32(4):342-351. Checklist available at https://www.ncbi.nlm.nih.gov/books/NBK92046/figure/ch4.fm1/ Accessed June 27, 2023.
7. Grech T, Marks A. Fast Facts and Concepts #319. Existential suffering – part 1: definition and diagnosis. 2016. https://www.mypcnow.org/fast-fact/existential-suffering-part-1-definition-and-diagnosis/ Accessed June 27, 2023.