Clinical Practice Procedures: Assessment/Pain

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Date	June, 2019
Purpose	To ensure a consistent procedural approach to pain assessment.
Scope	Applies to Queensland Ambulance Service (QAS) clinical staff.
Health care setting	Pre-hospital assessment and treatment.
Population	Applies to all ages unless stated otherwise.
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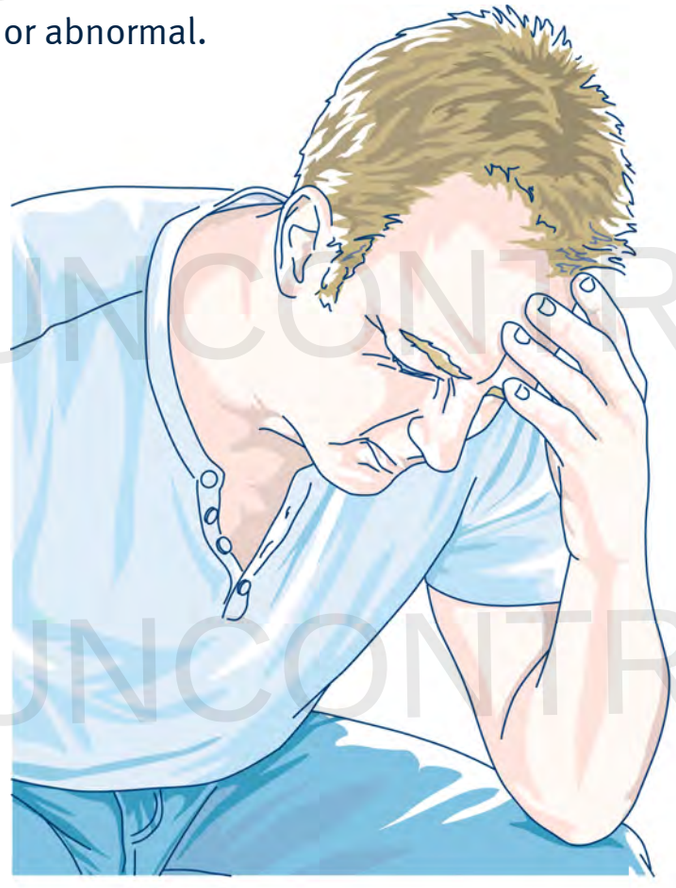
Pain

June, 2019

Pain is defined as a noxious stimuli associated with actual or potential damage to tissue. Patient response to pain or noxious stimuli is subjective and multifactorial involving both physical and psychological processes. Pain is sensed via afferent pathways in the nervous system and triggers the release of localised inflammatory mediators including bradykinin, prostaglandins, substance P, histamine, serotonin and potassium. Normally the sensation of pain provokes behavioural actions from the individual to remove themselves from, or reduce, the stimulus. The critically ill or injured patient may not be able to manage these responses or may have behaviours which would in other circumstances be considered irrational or abnormal.



Pre-hospital provision of pain relief has been recognised as a key area of contemporary ambulance practice. With this in mind clinicians should be able to accurately recognise, assess and treat patients' pain according to individual needs. Currently QAS uses numerical scales or standardised visual tools to gauge severity of patient symptoms. Clinicians should be able to assess a patient using these tools in accordance with physiological symptoms and vital signs.

Adequate analgesia does not necessarily mandate that a patient be pain free. This goal in certain instances is unattainable in the pre-hospital environment and high-dose analgesia may produce undesirable side effects. The clinician is expected to perform frequent pain assessments during the patients' time in care especially after the administration of analgesic medications.

Indications

- Any patient suspected of experiencing pain or discomfort

Contraindications

- Nil in this setting

Complications

- The absence of pain does not always indicate the absence of injury.
- Paediatric and geriatric populations have been identified as at-risk groups for not receiving adequate analgesia.[1]

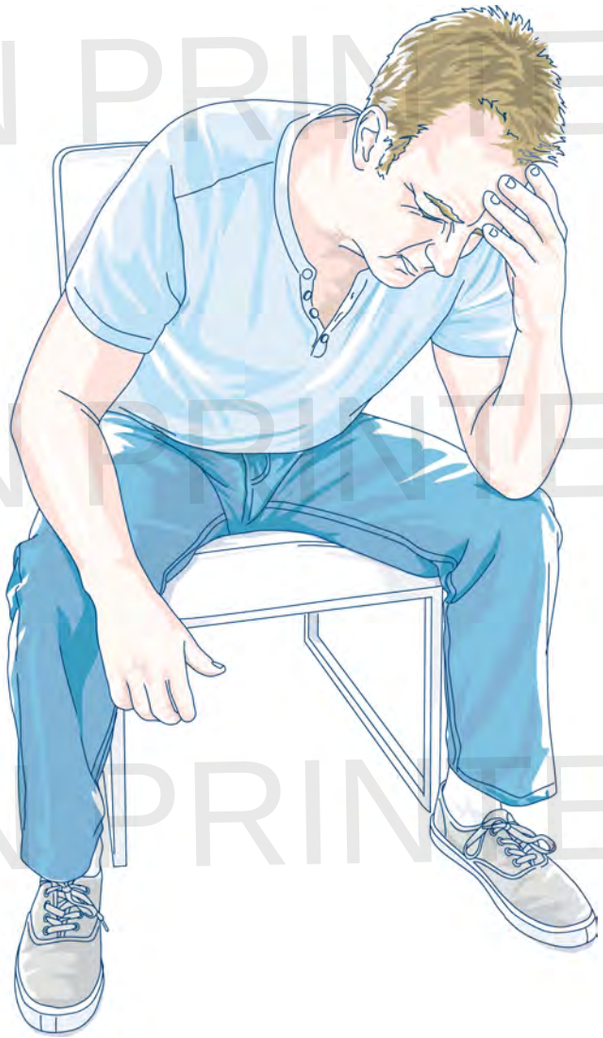
The assessment of pain is dependant on age, as well as the verbal and cognitive capacity of the patient. A commonly accepted mnemonic used for the assessment of pain is **OPQRSTT:**

- **Onset:** What was the patient doing when the pain started *(active, inactive, stressed)*, and was the onset sudden, gradual or part of an ongoing chronic problem.
- **Position/Palliation:** Where is the pain? Does anything make the pain better or worse?
- **Quality:** Describe the pain. For example is it dull, sharp or crushing.
- **Region/Radiation:** Does the pain radiate or move anywhere?
- **Severity:** How severe is the pain?
- **Timing:** When did the pain start and does it come and go?
- **Treatment:** Have you attempted self treatment or taken anything for your pain?

Self reporting of pain is the recommended method to assess severity. Strategies, for different age groupings, have been developed to assist in determining pain severity.

Adult

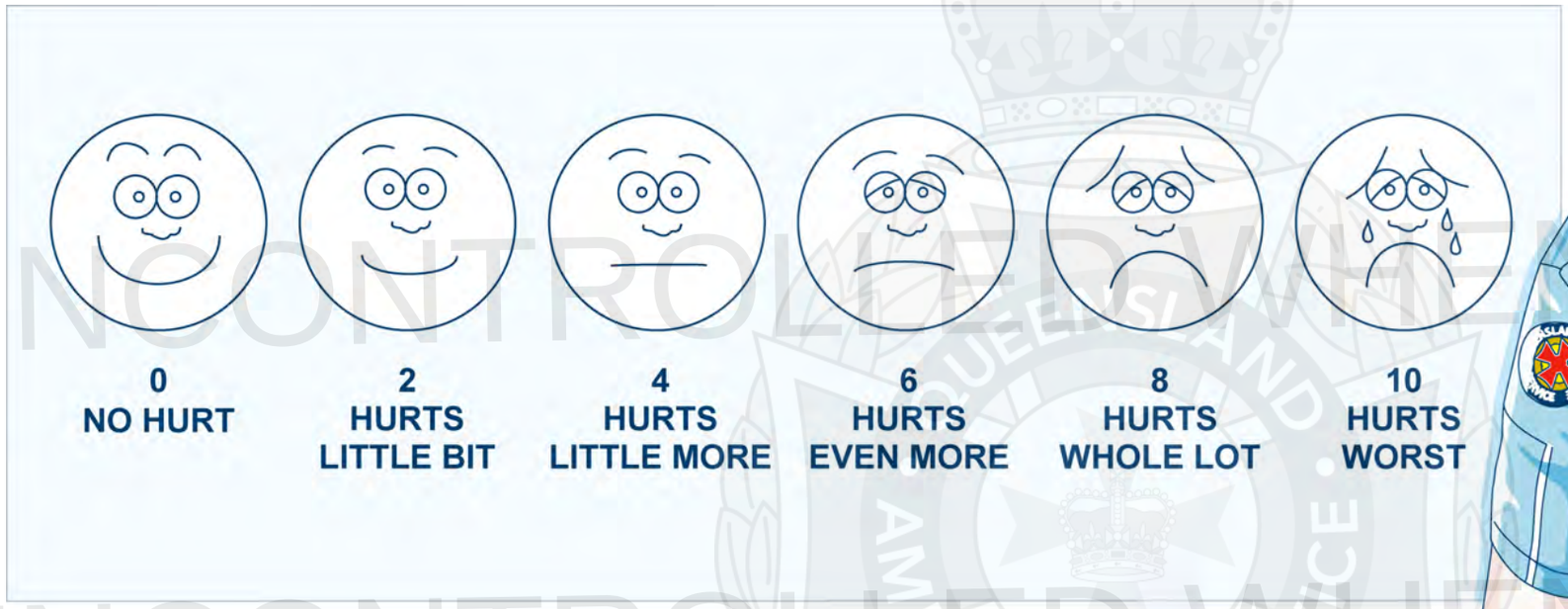
- The most common method for assessing pain severity in the adult is with a numerical rating scale of 0 to 10 (0 denoting no pain through to 10 denoting the worst pain imaginable).[2]
  - 0 = nil pain,
  - 1 – 4 = mild pain,
  - 5 – 7 = moderate pain,
  - 8 – 10 = severe pain.
- Should the patient be unable to comprehend the numerical scale, a verbal rating scale can be used with the patient describing severity as no pain, mild, moderate or severe.

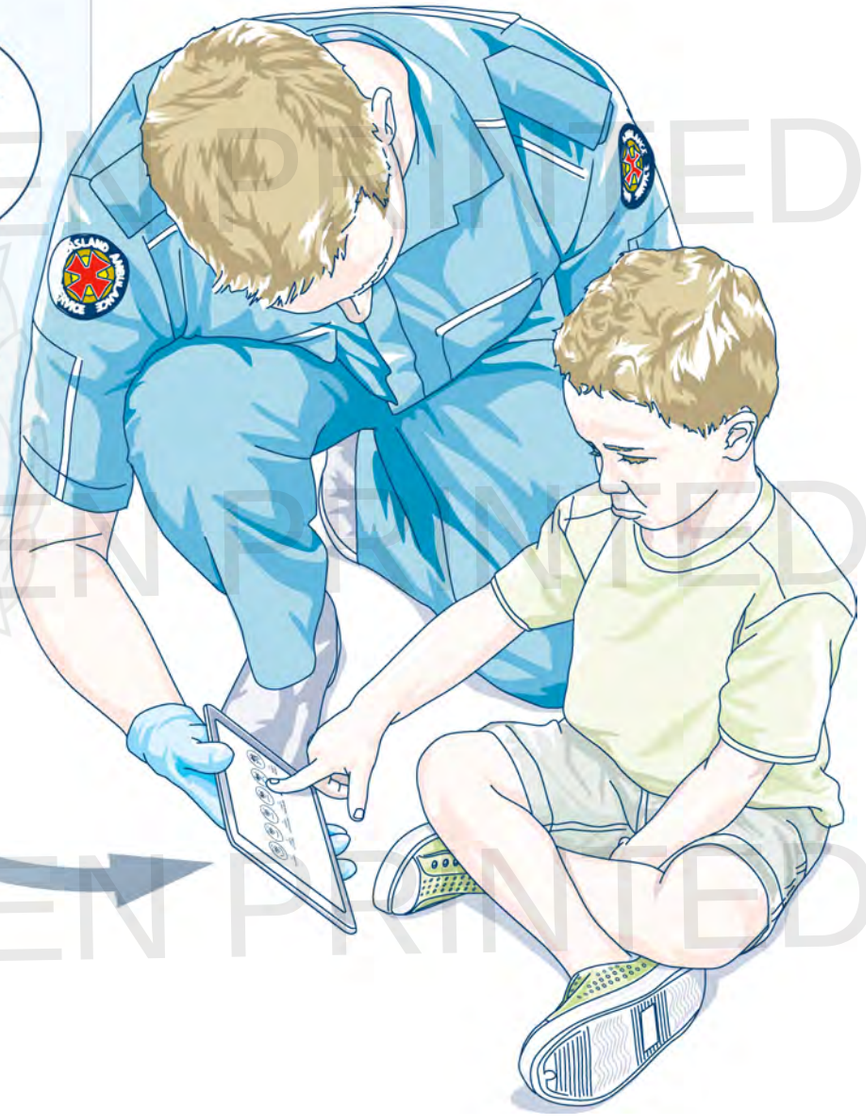


Child

- The Wong-Baker FACES Pain Rating Scale is the preferred severity assessment tool in children aged three and above.

Wong-Baker FACES Pain Rating Scale [3]





- Point to each face using the words to describe the pain intensity. Ask the child to choose a face that best describes their own pain and record the appropriate number.

From: Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8, St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.

Infant

- Behavioural cues may become the primary means to assess pain in infants who are unable to speak, comprehend or use self-reporting tools.
- This is achieved with the use of the FLACC behavioural assessment scale:[4]

Categories	SCORING		
	0	1	2
Face	No particular expression or smile	Occassional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
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, distracted	Difficult to console or comfort