Family Nursing & Home Care

Pain Assessment Policy

September 2020

Document Profile

Document Registration	Added following ratification
Type	Guideline
Title	Pain Assessment Policy
Author	Richard Deer Lara Deer
Category clinical / corporate / education / Health & Safety / HR / Info Governance	Clinical
Description	Guideline for effective pain assessment and subsequent actions
Approval Route	Organisational Governance Approval Group Meeting
Approved by	
Date approved	2 September 2020
Review date	1/3/5 years from approval
Document Status	This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Version control / changes made

Date	Version	Summary of changes made	Author
August 2020	1	New policy -	Lara Deer and Richard Deer

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1. INTRODUCTION

1.1 Rationale

Pain is one of the most common symptoms for people to seek medical attention, it defies age boundaries but with an increasing aging population the prevalence of co-morbid pain is increasing (Sturesson et al, 2016; Kang and Demiris, 2018). However, despite raised awareness and much research, pain remains significantly underreported as many consider it a normal consequence of aging, yet it is also commonly underestimated and undertreated amongst the paediatric population (Scholfield, 2018; Kang and Demiris, 2018; Bettramini, 2016; Royal College of Emergency Medicine, 2017).

Pain occurs throughout all clinical settings and, at times, continues to be poorly assessed despite effective assessment being pivotal to optimal management and improving patient outcomes (Motov and Khan, 2008; Royal College of Nurses, 2015; Schofield, 2018). The International Association for the Study of Pain (IASP) Declaration of Montreal (IASP 2010) cites the right of all people with pain to have access to appropriate assessment by adequately trained health care professionals. This is reflected within Royal College of Nurses (RCN) guidance highlighting the assessment and management of pain as essential components of nursing practice (RCN, 2015).

Pain is a complex phenomenon activated by a variety of stimuli encompassing the physiological, psychological and social elements of a patient's life (Scholfield, 2018; RCN, 2015). The subjectivity of the experience only adds to this complexity and needs to be embraced (National Pharmaceutical Council, 2001; RCN, 2015).

Ineffective pain assessment and the consequential sub-optimal management can have wide ranging and catastrophic consequences. Inadequate pain control conveys an increased risk of serious medical conditions e.g. Deep Vein Thrombosis or pneumonia; impairment to recovery times from injury and may lead to chronic pain conditions (NPC, 2001). The consequence of which can lead to an inability to perform normal activities of daily living and a decreased quality of life leading to an increased propensity to anxiety and depression (Gan, 2017; Sinatra, 2010). All of which have an associated individual and societal economic cost.

1.2 Scope

This policy have been developed for use with all FNHC patients under the care of the various nurse, health visitor and care teams within the organization.

1.3 Role and Responsibilities

1.3.1 The Chief Executive (CEO)
The CEO has overall responsibility for effective management of risk within the organisation. As Accountable officer, the CEO is responsible for the effectiveness of the organisation's systems of internal controls.

1.3.2 Operational Leads
Operational leads have responsibilities for ensuring that the required structures and resources are in place to enable effective pain assessment.

1.3.3 Team Leaders
Team Leaders have responsibility to ensure that all staff are aware of this policy and to encourage and monitor compliance with it and its related guidelines, protocols and procedures.

1.3.4 All Staff
All staff with face to face contact with patients have a responsibility to adhere to this policy within their own level of competency. If/when a scenario is encountered outside their normal remit staff should inform the relevant member of their team for further assessment/management and/or onward referral. All staff must identify and address any learning needs they may have in relation to it.

2. POLICY
During all face to face patient contact, regardless of the care speciality, staff will provide effective pain assessment to inform subsequent pain management. This will be undertaken without discrimination of age, gender, culture or cognitive ability.

2.1 Education, Training and Competence
The policy can be used in conjunction with the key RCN Pain Knowledge and Skills Framework document. Staff must ensure their knowledge and skills, pertinent to their job role and sphere of practice, are up to date. If necessary, Team Leads should be approached highlighting areas for development so training may be implemented.

3. PROCEDURE

3.1 Documenting Pain Assessment
Pain assessment utilising one of the tools outlined below should be employed on patient admission to the caseload. If using a NEWS chart, it may be documented there or, if not, on the relevant document/EMIS template used for admission assessment. Whilst remaining on the caseload, pain needs to be regularly re-assessed especially preceding and following any pharmalogical or non-pharmalogical pain intervention and documented in the same manner as initial assessment - thus achieving a standardised approach for each patient i.e. on a NEWS chart or EMIS template. It has been shown

that robust documentation of pain assessment improves its management (Sturesson et al, 2016). It is recognised that routine pain assessment may not be required within the paediatric caseload.

The use of the relevant assessment tool needs to be discussed with the patient and/or family member/carer ensuring their full comprehension of its use. The initial assessment needs to be discussed with the patient and/or family member/carer to ensure that as well as a level of intensity score is achieved that also the location of pain, any medication regularly used and prn, any non-pharmalogical methods employed in pain management, how it affects their daily lives and finally what level of pain is acceptable to the patient is assessed and documented. Pain assessment is not just about a completion of a scale but needs to explore a patient's pain experience (Schofield, 2018). This can be documented within an EMIS template or as free text.

The complexity and subjectivity of the pain experience is reflected by self-report being the gold standard for pain assessment (Schofield, 2018; NPC, 2001, Kang and Dimitris, 2018). The assessment tools below echo this philosophy where possible. To preserve continuity between in-hospital, ambulatory departments and the community settings, the research validated tools adopted by Health and Community Services (HCS) should be used.

Of the four tools utilised two are uni-dimensional and two are observational. Uni-dimensional tools, although favourable in many aspects, are restricted in how they reflect the pain experience. As health practitioner responsibilities expand into Advanced Practice and Non-Medical Prescribing roles, multi-dimensional tools will have to be employed to reflect the level of assessment/consultation undertaken.

3.2 Pain Assessment Tools

3.2.1 Numerical Pain Rating Scale (NPRS)

The NPRS-11 is an 11-point scale for self-report of pain. It is a quick and easy to use tool that has been validated for numerous pain types' e.g. acute, cancer and chronic (NPC, 2001). The tool may be used with most adults and children > 10 years old, and has also been shown to be reliable for mild to moderately cognitively impaired adults, in whom self-report often remains the gold standard (Schofield, 2018). The tool has been shown to have high test-retest reliability (The British Pain Society, 2019). Utilising 11-points increases its sensitivity to expressing change within the pain experience. Although uni-dimensional and primarily used to measure the intensity of pain it may be utilised to measure other aspects i.e. pain interference (The British Pain Society, 2019). A standardised language is necessary for the scale anchors therefore 0 = no pain at all and 10 = worse pain imaginable. Although it is agreed that standardised language is required no specific upper anchor is expressed in the literature

(Castarlenas et al, 2017). Contrastingly, eliciting an accurate pain response in older adults may require the use of differing terms such as discomfort, numbness or aching (McClean and Cunningham, 2007; Schofield, 2018). Thus, to maintain accuracy and reliability the assessment must be adjusted to the demographic.

3.2.2 Abbey Pain Scale

The latest UK National Guidelines (2018) recommend for people with severe cognitive impairment the use of one of two tools, Pain in Advanced Dementia (PAINAD) or Doloplus-2, as continuing research is showing positive results in reliability and validity (Schofield, 2018). However, the Abbey Pain Scale (Appendix 1) continues to be widely used and appears the most user friendly. Although it has been validated showing good reliability, there has been no recent evaluation (Schofield, 2018). As HCS guidelines employ the Abbey Pain Score, for continuity in the patient's journey FNHC will acquiesce.

The Abbey Pain Scale (Appendix 1) is an observational behavioural pain assessment tool developed for people with end or late stage dementia using 6 categories of appraisal to establish the probability the person, unable to articulate, is experiencing pain. It is not without its limitations as firstly it cannot distinguish between pain and distress of another origin and relies on the interpretation by nursing staff/carers who, when known to the person, may be a positive influence but otherwise may lead to over or under treatment (Brown, 2011).

It is best utilised in a movement based assessment with the scale being completed immediately after the procedure and the resulting pain score recorded on the assessment chart along with the time, name of assessor and action taken (The Australian Pain Society, 2005). A repeat assessment, if possible, should be performed to assess the intervention. If time prohibits immediate reassessment, discuss with the carer/family on next visit to evaluate effectiveness.

3.2.3 The Wong-Baker 'Faces' Pain Scale

The Wong-Baker 'Faces' pain scale (Appendix 2) is renowned to be the preferred, reliable and valid tool in assessing pain in children aged 3 and above (Walker, Polaner, and Berde, 2019). Its creators recognised the need to create a tool that had been designed with children, for children. This being central to the design process ensures that children can be helped to clearly communicate their pain experience to then facilitate that they receive appropriate analgesia (Wong-Baker Foundation, 2016).

The tool is not to be used by anyone other than the patient – it is a self-assessment tool that must be clearly explained before use. Each face represents a person who may have no pain, some pain, or a lot of pain. The carer must point to each face as the explanation is given and starting with Face 0 explain that this person doesn't have

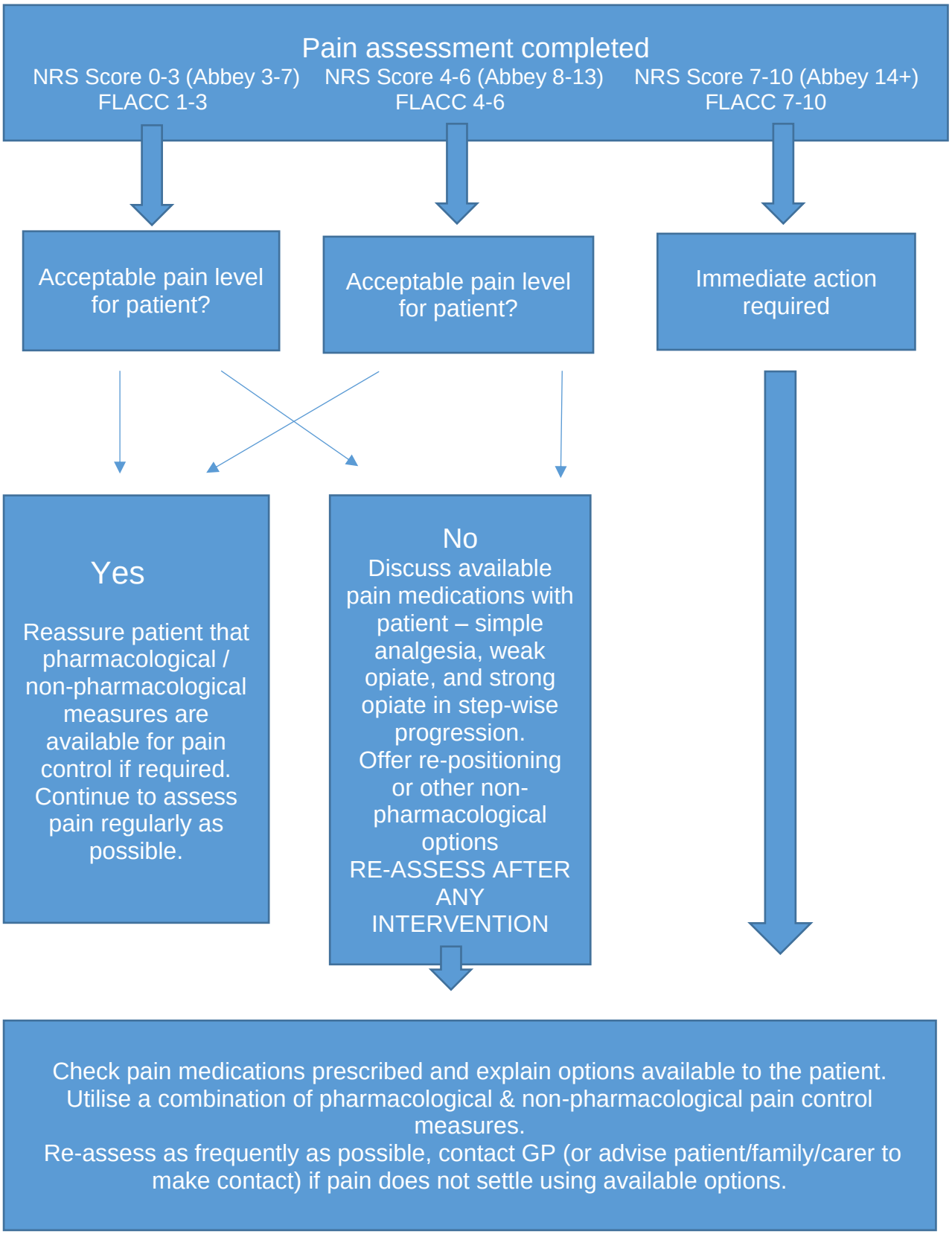
any pain, moving through all the descriptors of the scale and ending with face 10 - hurting as much as the patient can imagine. It is important to state that to identify their pain with face 10 the patient doesn't have to be actually crying. (Appendix 2).

3.2.4 The FLACC Scale

The FLACC pain scale (Appendix 3) is an acronym which identifies 5 standard categories of potential pain behaviour in young children – **F**acial expression, **L**eg movement, **A**ctivity, **C**ry and **C**onsolability. It has been recognised as a valid and reliable pain assessment tool to assist in quantifying pain in children aged 2 months to 7 years who are unable to verbalise the presence of pain they may be experiencing or specify pain intensity (Voepel-Lewis *et al*, 2010). It should only be used if the 'Faces' tool is not appropriate to be used to self-report. To use the tool the child must be observed for 1-5 minutes and each category rated by closely matching the behaviour of the child with the descriptors. If the child is already known then descriptors may be adopted within the categories to mirror their previously recognised behaviour thus individualising the assessment tool. The numbers obtained are then added together to create a pain score out of 10 (Appendix 3).

3.3 Pain Assessment Flow Chart

The below flow chart has been adapted from HCS Pain Assessment policy (2019) for use within the community.



4. CONSULTATION PROCESS

Name	Title	Date
Clare Stewart	Operational / Clinical Lead Out of Hospital Services	13/7/2020
Claire White	Head of Quality, Governance and Care	13/7/2020
Elspeth Snowie	Clinical Effectiveness Facilitator	13/7/2020
Michelle Cumming	Operational Lead for Child and Family Services	13/7/2020
Tia Hall	Operational Lead for Adult services	13/7/2020
Gill John	Team Lead for Adult services	13/7/2020
Julia Foley	Team Lead for Adult services	13/7/2020
Joanna Champion	Team Lead for Adult services	13/7/2020
Jessica Clarke	Team Lead for Adult services	13/7/2020
Angela Stewart	Team Lead for Adult services	23/7/2020
Louise Hamilton	Team Lead for RRRT	23/7/2020

5. IMPLEMENTATION PLAN

A summary of how the document will be implemented with time frame

Action	Responsible Person	Planned timeline
Email to all staff	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Policy to be placed on organisation's Procedural Document Library	Secretary/Administration Assistant (Quality and Governance Team)	Within 2 weeks following ratification
Staff to sign up to documents if relevant	Operational Leads/Departmental Senior Manager	Within 1 month following ratification

6. MONITORING COMPLIANCE

Team Leaders have responsibility to monitor competent compliance of pain assessment in relation to this policy within an individual's sphere of practice. It is the responsibility of all staff to adhere to this policy within their own level of competency.

7. EQUALITY IMPACT STATEMENT

This policy is compliant with both Article 25 of the United Nations Universal Declaration of Human Rights (1948) and the Convention on the Rights of the Child (1990).

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively
- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity
- ✓ Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times.

See Appendix 4 for the Equality Impact Assessment for this policy.

8. GLOSSARY OF TERMS

9. REFERENCES

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10. APPENDIX

Appendix 1 Abbey Pain Scale

Patient identification sticker

	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time	Date & time
Vocalisation Whimpering, crying, and groaning. Absent 0 Mild 1, moderate 2, Severe 3								
Facial expression Looking tense, frowning, grimacing, looking frightened Absent 0 Mild 1, moderate 2 Severe 3								
Change in body language Fidgeting, rocking, guarding part of body, withdrawn Absent 0 Mild 1, moderate 2 Severe 3								
Behavioural change Increased confusion, refusing to eat, alteration in usual patterns Absent 0 Mild 1, moderate 2 Severe 3								
Physiological Changes Temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor Absent 0 Mild 1, moderate 2, Severe 3								
Physical Changes Skin tears, pressure areas, arthritis, contractures, previous injuries Absent 0 Mild 1, moderate 2 Severe 3								
Total Score								
Signature of person completing score								
	0-2 No Pain		**3-7 Mild Pain**		**8-13 Moderate Pain**		**14+ Severe Pain**	

Adapted from: Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D; and Lowcay, B. Funded by the JH and JD Gunn Medical Research Foundation 1.

Appendix 2 The Wong-Baker ‘Faces’ Pain Scale

Instructions

Explain to the child that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain.

Face 0 is very happy because he doesn't hurt at all (NRS 0)
Face 1 hurts just a little bit (NRS 1-2)
Face 2 hurts a little more (NRS 3-4)
Face 3 hurts even more (NRS 5-6)
Face 4 hurts a whole lot more (NRS 7-8)
Face 5 hurts as much as you can imagine, although you do not have to be crying to feel this bad (NRS 9-10)

Ask the child to choose the face that best describes how he/she is feeling

Appendix 3 FLACC Scale for the assessment of pain in infants or non-verbal children

	SCORING		
Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, 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; distractible	Difficult to console or comfort

Each of the five categories Face (F), Legs (L), Activity (A), Cry (C) and Consolability is scored from 0-2, resulting in a total score between 0-10.

Appendix 4 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document:			
Date of Assessment	27/8/2020	Responsible Department	Family Nursing and Home Care
Name of person completing assessment	Richard Deer	Job Title	Deputy Charge Nurse

Does the policy/function affect one group less or more favourably than another on the basis of :		
	Yes/No	**Comments**
• Age	No	
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	No	
• Ethnic Origin (including gypsies and travellers)	No	
• Gender reassignment	No	
• Pregnancy or Maternity	No	
• Race	No	
• Sex	No	
• Religion and Belief	No	
• Sexual Orientation	No	
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions** **(what needs to be done to minimise / remove the impact)**	**Responsible Officer**

Monitoring of Actions

The monitoring of actions to mitigate any impact will be undertaken at the appropriate level