Pain Assessment and Pain Management Podcast – Episode 1

Introduction: Welcome to the Pain Management Podcast. This series is a part of a larger pain, hypertension and cardiovascular disease initiative to educate providers on patient pain and medication management with considerations for over-the-counter pain relief for patients with high blood pressure and cardiovascular disease.

This series portrays the patient and clinician's experience with assessing and managing pain. This podcast is intended to be a guide to educate providers on the pain assessment tools available and provide practical applications for assessing and managing pain at different stages in the patient's journey. The patient used in this series is an actor who is a 65-year-old Black man with a history of hypertension, hyperlipidemia and obesity, who had a knee replacement surgery. Any recommendations or information provided are not to be construed as a directive, endorsement or medical advice.

Disclaimer: The opinions expressed in this podcast are solely those of the presenter and not necessarily of the American Heart Association/American Stroke Association (AHA/ASA). The AHA/ASA does not endorse any specific products or devices.

[Start reenactment]

PAUL ARNSTEIN: Hello Mr. Williams, my name is Paul Arnstein, a nurse practitioner here with the Orthopedic Team. I wanted to evaluate your pain after yesterday's surgery. How are you feeling?

MR. WILLIAMS (patient): It's not too bad, the numbing medicine helps.

PAUL ARNSTEIN: On a scale of 0-10 how strong would you say your pain is?

MR. WILLIAMS: I'd say a "zero." It's not really pain; it's more like soreness.

PAUL ARNSTEIN: Ok, well, if "zero" is "no soreness," and "ten" is "the worst soreness imaginable," how strong is the soreness right now?

MR. WILLIAMS: I can't really put a number on it.

PAUL ARNSTEIN: Well Frank, would you say that it is "absent," "mild," "moderate," "severe," "very severe," or "the worst possible" soreness?

MR. WILLIAMS: Probably between "mild" and "moderate."

PAUL ARNSTEIN: Okay. Thank you. I'm just going to bend that knee a little and see how you do.

MR. WILLIAMS: Oh, no, no, no … don't touch it! It will hurt if it moves.

PAUL ARNSTEIN: Well, let me see how much you can move it on your own before the pain becomes intolerable. Hmm…you can barely move it.

MR. WILLIAMS: (Sighs) Well, that's the best I can do right now.

PAUL ARNSTEIN: Well, the physical therapist is coming in an hour to get you out of bed. Can I get you something for the pain?

MR. WILLIAMS: I told you I don't have pain, and I don't like taking medicine. Can you just turn the TV volume back up and go?

PAUL ARNSTEIN: Yeah, I can go. If you like, the cryocuff ice pack can help before P.T. comes.

MR. WILLIAMS: No. I'm fine. Now, just go.

[Begin Interview]

KRISTIN COLSON: Welcome to episode one of this Pain Assessment and Pain Management three-part podcast series. My name is Kristin Colson, and I am a Quality Programs Manager with the American Heart Association. Here with me today is Paul Arnstein. Paul is a certified family nurse practitioner, clinical nurse specialist, and a pain management nurse. He is also an adjunct professor of nursing at the Mass General Hospital Institute of Health Professions and an independent pain educator and consultant. Thanks for joining us, Paul.

PAUL ARNSTEIN: Thank you for having me.

KRISTIN COLSON: As we just heard, the patient, Mr. Williams, told you that his soreness was at "zero," but he was showing behavioral signs of pain. Does this happen often?

PAUL ARNSTEIN: He indicated his pain was a "zero," but given his behavioral signs of pain, I used his word of "soreness" as a proxy measure for pain, but he still couldn't quantify it on a numeric intensity scale.

KRISTIN COLSON: Thanks, Paul. Sounds like you would need to consider different tools for assessing pain in this instance. As we know, evidence-based practices support the use of different pain intensity scales. What are the different types of scales, and how do you know which to use?

PAUL ARNSTEIN: Given that pain is a very personal, subjective experience, the patient's self-report of pain intensity is considered the gold standard for assessing it. Common tools ask the patient to say or point to a number, a word or a face representing

its intensity. The written or digital display of these scales typically have anchors of "No pain" on the left and "Worst pain" on the right. Proper use requires correctly identifying the meaning of the anchors representing the range of acceptable responses. Some scales, like the FACES Scale, require the professional to explain the meaning of each response option to get an accurate measure.

KRISTIN COLSON: Oh, so the FACES is not a scale reflecting the patient's facial expression?

PAUL ARNSTEIN: No. The FACES Scale measures a patient's self-report of intensity of their discomfort by pointing to one of six faces representing either "no hurt," "hurts a little," "hurts a little more," "hurts even more," "hurts a whole lot," or "the worst hurt."

Noticing a patient's facial expression is an important point though. In my experience, a significant proportion of hospitalized patients are unable to self-report pain (like pre-verbal children, critically ill or delirious patients), and we have to use objective, behavioral measures of pain. These validated scales have the professional rate a series of behavioral indicators of pain as being "absent," "somewhat or intermittently present," or "definitely and constantly present." Examples of pain behaviors include facial grimace; moaning, crying out or ventilator asynchrony; restlessness or protective movements; inconsolability; and other behaviors specific for the target population.

KRISTIN COLSON: Hmm. These sound kind of vague. Why wouldn't you just check the vital signs?

PAUL ARNSTEIN: In fact, they are vague and vary between individuals, but measuring vital signs isn't accurate in most settings. If you're constantly monitoring pain during a procedure or surgery and see a 10-20% spike in pulse and blood pressure, that's a sign of pain, but the body soon adapts to these vital signs. They stabilize, or they're treated with medications that suppress these responses. Although vague, assessing all categories of validated pain behaviors helps you recognize subtle signs of pain. Behavioral measures of pain don't provide an intensity score, rather the higher the score, the more likely it is that the observed behavior represents pain. We can increase our confidence that we're dealing with pain through surrogate reporting by those who know the patient best and seeing if the behaviors improve the most with an analgesic, versus other symptom-modifying medications like sedatives for agitation or antipsychotics for delirium.

KRISTIN COLSON: So, you can measure pain using self-report or behavioral observations, but not both?

PAUL ARNSTEIN: Well, use self-report scales when the patient is able to convey pain, but it's important to observe behaviors that may signal pain, without using those observations to discredit the patient's self-report. I use a blended approach that utilizes the self-report scale that is easiest for the patient to understand and conveys meaningful clinical information combined with observations. By using the Functional

Pain Scale with Mr. Williams, I could gauge not just its intensity, but its tolerability and interference with functioning.

KRISTIN COLSON: So, ultimately, what scale did you think was best for Mr. Williams?

PAUL ARNSTEIN: Mr. Williams was able to engage in a conversation about his discomforts, so a self-report measure was best. I started with the frequently used Numeric Rating Scale attempting to have him rate his pain on a 0-10 scale. He denied the presence of pain, rating it as a "zero," but indicated he had "soreness." Given the stigma associated with admitting you have pain, or motivation to avoid unwanted tests or treatments, many people will deny or underreport the presence of pain. Since he admitted to "soreness," I tried to get him to rate his soreness on a 0-10 scale, but he couldn't put a number on it. So, I switched to a Verbal Descriptor Scale asking him to rate it as "absent," "mild," "moderate," "severe," "very severe," or "the worst possible" soreness. On the Functional Pain Scale, I evaluated its tolerability and interference with functioning. So, either the Simple Descriptive or Functional Pain Scales would work for this patient. If I had to decide on one, I would ask Mr. Williams which one he thought best represented his discomfort.

KRISTIN COLSON: In Mr. Williams' case, is there an advantage to choosing one over the other?

PAUL ARNSTEIN: Yes, since many people guard against pain, I like to assess pain with movement. In this case, I prefer the Functional Pain Scale. The pain was tolerable at rest and while engaging in passive activities like talking to me or watching TV but became intolerable with even the slightest movement of his knee.

KRISTIN COLSON: Okay, so you've told us about the Functional Pain Scale, but what about the CAPA scale known as the clinically aligned pain assessment tool? How is that different?

PAUL ARNSTEIN: Well, the CAPA Scale is a structured conversation that you have with the patient, inquiring about pain tolerability, recent changes, the effect pain has had on functioning and sleep. It also includes a discussion on treatment efficacy.

KRISTIN COLSON: In that case, how would you document his pain intensity?

PAUL ARNSTEIN: Well, the CAPA Scale is based on the premise that the assessment dialog should drive care and documentation, not the other way around. Some electronic health records have a variety of these tools that can be selected on the flowsheet, where they are most visible to others. If that were the case, I would document using the Simple Descriptor Scale or the Functional Pain Scale. If the Numeric Rating Scale were the only option, I would rate it as a "3" and enter in the Comments section, "mild-moderate" on Simple Descriptor Scale, since research using these two scales correlates "2" as "mild" and "4" as "moderate intensity" pain, I would describe the Functional Pain Scale findings in the Progress Notes as, "pain becomes intolerable with active range of motion of the right knee; refusing passive range of motion attempts of

the right knee." For continuity of care, I would discuss with colleagues whether the Simple Descriptive Scale or Functional Pain Scale was the most easy and meaningful one to use for this patient.

KRISTIN COLSON: Great, I think we've all learned a lot from today's conversation. Again, thank you Paul for joining us today. In the next episode of this three-part series, we will be discussing the importance of assessing harm and the risks for adverse outcomes related to pain treatment for patients with co-morbidities. See you next time!

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