Clinical Resource Guide:
Pain Assessment in the Hospice Setting

INTRODUCTION TO PAIN ASSESSMENT

A quality, comprehensive pain assessment is the cornerstone of effective pain management. Without understanding the personal pain experience of the patient, it is impossible to know what tools are required to reduce pain to a tolerable level, alleviating unnecessary suffering at or near the end of life. In addition to effectively addressing patient symptoms, the development and utilization of a comprehensive pain assessment can also ensure patient and family goals are respected, clarify monitoring strategies, and simplify pharmacologic analgesic regimens. This Pharmacist Corner was created to serve as a resource to hospice administrators and clinicians by providing guidance on the following:

Pharmacist Corner Objectives

1. List components necessary for a comprehensive pain assessment
2. Identify patient and agency associated barriers to effective pain management
3. Recognize situations in which traditional assessment tools may not adequately assess your patient and know what tools to utilize
4. Differentiate between nociceptive pain, neuropathic pain and total pain

THE PREVALENCE OF PAIN IN THE HOSPICE SETTING

While the NIH has reported the vast majority of patients with cancer are reported to experience pain during the course of their illness, this is not the only subset of hospice patients subjected to pain at the end of life. Thanks in part to the advancements of modern medicine, many patients are living longer with chronic disease than ever before in history. As a result, many Americans are living longer with chronic diseases, and cancer is not the only end-stage illness associated with significant pain. Per reports from the NIH, up to 80% of patient with AIDS, 77% of COPD and 40% of heart failure patients experience significant pain at the end of life. Pain is also one of the most common reasons for a health-care related visit. The distressing nature of this symptom can heighten anxiety of both the patient and family, and result in an unplanned hospital emergency department visit and/or hospital admission if not properly managed.

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IMPLICATIONS OF UNRELIEVED PAIN

FUNCTIONAL DOMAIN	STRESS RESPONSE TO PAIN	CLINICAL MANIFESTATION
Endocrine/Metabolic	altered release of multiple hormones: ACTH, cortisol, catecholamines, insulin	weight loss, fever, increased respiratory rate, increased heart rate, shock
Cardiovascular	increased heart rate, vascular resistance, increased blood pressure, increased myocardial oxygen demand, hypercoagulation	unstable angina, myocardial infarctions, deep vein thrombosis (DVT)
Respiratory	increased air flow due to involuntary (reflex muscle spasms) and voluntary (splinting) pathways	atelectasis, pneumonia
Gastrointestinal	increased rate of gastric emptying, increased intestinal motility	delayed gastric emptying, constipation, ileus, anorexia
Musculoskeletal	muscle spasm, impaired muscle mobility and function	immobility, weakness, fatigue
Immune	impaired immune function	increased risk of Infection
Genitourinary	abnormal release of hormones, affecting urine output, fluid volume, and electrolyte balance	increased urine output, hypertension, electrolyte disturbances

GOALS OF THE PAIN ASSESSMENT

1. To ***understand*** the patient’s perspective
2. To elicit ***pain specific history*** to aid in establishing/clarifying pain diagnosis.
3. To formulate an understanding of the ***nature of pain***
4. To characterize the ***impact of pain on patient quality of life***
5. Identify ***significant comorbidities***.
6. To clarify the results of ***previously attempted pain management strategies***
7. To identify and ***consider psychiatric comorbidities***
8. To determine other ***needs of supportive interventions for patient and caregiver***

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BARRIERS TO EFFECTIVE PAIN MANAGEMENT

Patient Barriers	Provider/Healthcare System Barriers
Reluctance to report: ○ Concern of worsening disease ○ Concern of being perceived as drug seeking	**Fear of opioid-related adverse event**: ○ May result in undermanagement of pain ○ Premature opioid rotation/taper
Noncompliance: ○ Physically unable (access, dexterity, route) ○ Limited health literacy	**Lack of pain management expertise**: ○ Unfamiliarity with managing pain at end of life ○ Understanding of hospice appropriate treatment
Fear of addiction: ○ Previous history of substance use disorder ○ Concern of perception by family, friends	**Lack of time/accessibility for in-person assessment**: ○ Provider schedule impacts reassessment ○ Titration/tolerability not adequately assessed
Unrealistic Expectations: ○ Goal of being pain free with treatment ○ Stopping medication due to lack of response	**Evolving opioid prescribing regulations**: ○ Providers avoid or limit use due to uncertainty ○ E-prescribing credentials not up do date

PERFORMING THE INITIAL PAIN ASSESSMENT

Prior to initiating the pain assessment, it is important to assure the patient and their support network that the goal of your efforts are to decrease symptom burden while working to honor the wishes of the patient. The development of a therapeutic relationship between the patient/caregiver and the hospice provider is important to ensure the development of trust necessary to manage the patient throughout the disease course.

If possible, a clinician performed physical assessment should be completed to identify reversible causes of pain (e.g., constipation, edema, wound, infection, etc.)

CORE COMPONENTS OF A COMPREHENSIVE PAIN ASSESSMENT

- Ensure patient with capacity to appropriately engage in assessment
- Include key members of patient support team if necessary
- Documentation of assessment is necessary to evaluate efficacy and ensure proposed treatment plan is aligned with patient goals
- Considerations of setting, abilities and support are critical to ensuring viability of the treatment plan.
- Utilization of the PQRSTU Pain Assessment Tool

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THE PQRSTU PAIN ASSESSMENT PNEUMONIC

While the order in which the components of the assessment can be modified to fit the conversation style of clinician, the general outline should remain relatively unchanged to provide the most thorough assessment of pain.

P	***Palliating, Precipitating/Provoking Factors***: What makes pain better? Worse?
Q	***Quality of Pain***: How it feels to the patient, often through descriptive words
R	***Region, Radiation, Referral***: Where does it hurt? Does the pain move or travel?
S	***Severity***: On a scale of 0-10, ain intensity
T	***Temporal***: onset, duration, daily fluctuations
U	***You-associated Factors****:* how does pain impact your quality of life and well-being

Palliating, Precipitating/Provoking Factors

- Questions from this category can be used to identify what exacerbates the patient's pain and what provides relief. These answers can provide insight into the physiology of the patient's pain and identify opportunities to optimize the analgesic regimen based on patient-specific response.
- Opioid-sparing analgesic opportunities may be identified as a result of working through this question

Quality of Pain

- The words the patient uses to describe the pain
- Avoid prompting the patient and encourage them to describe their pain, as it is a unique, personal, complex experience
- When necessary, providing the following descriptive words may be helpful to elicit a patient response
- Pain reported as burning may indicate a neuropathic pathogenesis, and an adjuvant analgesic may be considered to optimize analgesia.

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Region, Radiation, Referral:

- Where is the pain located? Is it isolated to a single location or multiple sites? If multiple sites, is one site more bothersome than the others or is it uniform across all sites? If uniform is this pain acute or chronic in nature? Have psycho-social elements been considered
- Does the pain radiate from the identified site to anywhere, or does it remain localized?
- If localized, is it consistent with an area of metastases or area, trauma or other event that could explain the pain experienced by the patient?
- Does the patient have pain in area where it is commonly referred and a oncologic diagnosis consistent with this finding

Severity

- Using the Numeric Rating Scale (NRS) on a scale of 0-10
- Preface the assessment of severity by stating that “zero” indicates no pain and “ten” is the worst pain they could ever imagine, not that they have ever experienced. Often the question of severity is asked “On a scale of 1-10….” Implying the patient is experiencing pain of at least a 1, and with lack of clarity to what 10 means.
- To provide an understanding pain severity across time, ask patient to identify severity at the time of the assessment, then about the worst the pain has been since the most recent visit, and the best (or lowest) the patient’s pain has been since the time of most recent assessment

Temporal Aspects of Pain

- When was initial onset of pain?
- When does the pain occur or is at its worst during the day?
- When an immediate-release pain medication is taken, how long does it take for patient to experience relief? To what extent is pain reduced? For how long?
- When a long-acting analgesic regimen is prescribed, does patient receive relief for entirety of dosing window, or is end of treatment failure (increasing pain experienced before the next dose available) a common occurrence? If so, is a frequency increase possible for the drug/formulation currently prescribed?

You-associated Factors

- What impact does pain have on activities of daily living? On sleep? On activities of enjoyment/pleasure?
- What goals does the patient have that are inhibited by pain?
- What impact does pain have on patient relationships and intimacy?

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SAMPLE PAIN ASSESSMENT TEMPLATE FOR USE IN THE HOSPICE SETTING

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Pain Assessment:
-History of substance use:
-Previously Trialed analgesics:
-Current pain regimen:
-PRN usage:
-Morphine equivalent daily dose:
-Pain Assessment:
 1.) Location of pain (painful sites, radiation, etc.):
 2.) Quality:
 3.) Intensity (pain score on scale):
        -Current __/10 (__ hrs since most recent analgesic dose)
        -Worst (in the previous __ days): __/10
        -Best  (in the previous __ days): __/10
 4.) Pain Goal (numeric scale value/functional goal/other):
 5.) Pain Frequency (onset, duration during last 24 hours):
 6.) Factors precipitating pain:
 7.) Factors palliating pain:
 8.) Effect on daily life:
 9.) Additional Notes:
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