



Los Angeles County Department of Health Services

Policy & Procedure Title:	DHS Pain Assessment Tool Policy		
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PURPOSE:

The purpose of this policy is to provide a standardized guideline for workforce members to assess and measure patients’ pain using the appropriate evidence-based pain assessment tool.

DEFINITION(S):

Pain Rating:

A numerical value or score based on a specific scale associated with the presence/absence of pain and indicating the severity/intensity of pain if present.

Pain Scale:

A range of scores associated in the assessment and measurement of pain.

Pain Tool:

A clinical instrument used for pain assessment that has been empirically and widely tested and shown to demonstrate reliability and validity.

PAIN ASSESSMENT TOOLS:

Assumed Pain Present (APP):

APP is the culmination of a pain assessment of a nonverbal patient, “usually when there is no appropriate behavioral assessment instrument to quantify behaviors systematically.” (Quinn, 2006). This includes patients who are unresponsive due to traumatic brain injury,

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pharmacologically induced coma or neuromuscular blockade. Pain is assumed to be present in these patients. Analgesics will be administered when clinically indicated.

Critical-Care Pain Observation Tool (CPOT):

A behavioral scale used to quantify pain by using four behavioral categories: facial expression, body movements, muscle tension and compliance with the ventilator or vocalization of the extubated patient. Each behavior is rated from 0 to 2, which results in a total score of 0 to 8. Presence of pain is suspected when the CPOT score is greater than 2 or when the CPOT score increases by 2 or more. It is used for adult patients who are unable to communicate verbally secondary to mechanical ventilation, sedation, and changes in level of consciousness.

Face, Legs, Activity, Cry and Consolability (FLACC) Scale:

A behavioral scale used to quantify pain by using five categories: Face, Legs, Activity, Cry and Consolability. Each category is scored on a 0-2 scale which results in a total score of 0 to 10, with zero (0) being no pain and ten (10) being the worst possible pain. It is used for scoring pain in (a) children up to 5 years (b) patients who are developmentally delayed (c) patients who have difficulty understanding a NRS and/or Faces Scale who are greater than 5 years of age and (d) patients who may not be able to verbalize the presence/severity of pain or are non-communicative.

Faces Scale:

A visual pain assessment tool featuring images of facial expressions to help the patient describe the intensity or severity of pain. Each facial expression consists of a numerical score which correlates to a pain intensity on a scale of 0 to 10, with zero (0) being no pain and ten (10) being the worst possible pain. The Faces scale is used for populations greater than 5 years of age.

N-PASS (Neonatal Pain, Agitation, and Sedation Scale):

A pain tool used for neonates/infants in the Neonatal Intensive Care (NICU) unit.

Pain should be presumed in neonates/infants in all situations that are usually painful for adults and children, and treatment should be used if there is any possibility of pain. This pain scale is documented as 0 to 10 or 11. If the patient is ≥ 30 weeks gestation, pain intensity is rated on a scale of 0-10, with zero (0) being no pain and ten (10) being the worst possible pain. If the patient is <30 weeks gestation/corrected age, pain intensity is rated on a scale of 0-11, with zero (0) being no pain and eleven (11) being the worst possible pain.

Numerical Rating Scale (NRS):

A numeric pain assessment tool, in which patients are asked to verbally rate their current pain intensity on a scale of 0 to 10, with zero (0) being no pain and ten (10) being the worst possible pain. The NRS is used for population greater than 5 years of age.

POLICY:

All patients will be assessed and treated effectively for pain consistent with regulatory and accreditation standards.

SCOPE:

This policy and procedure applies to all workforce members who are assigned to a Department of Health Services (DHS) patient care area. This policy aligns with each DHS facility's Pain Management policies and procedures.

PROCEDURE:

1. Use the LA County DHS pain assessment tools to determine the presence of pain in patients as appropriate.
2. Gather pain data and/or assessments in accordance to scope of practice and healthcare standards.
3. Follow the pain management policies, procedures and protocols for assessment/reassessment, treatment and documentation.

REFERENCES/AUTHORITY:

American Pain Society. (2012). Pain: Current understanding of assessment, management, and treatments. Retrieved from <http://www.ampainsoc.org/education/enduring/downloads/npc/npc.pdf>.

American Society for Pain Management Nursing. (2012). Pain assessment in the patient unable to self-report: Position statement with clinical practice recommendations. Retrieved from http://www.aspmn.org/Organization/documents/UPDATED_NonverbalRevisionFinalWEB.pdf.

Arbour, C.& Gélinas, C. (2011). Ask the experts: Setting goals for pain management when using a behavioral scale: Example with the Critical-Care Pain Observation Tool. *Critical Care Nurse*,31, 66-68.

Gélinas, C., Arbour, C., Michaud, C., Vaillant, F., & Desjardins, S. (2011). The implementation of the Critical-Care Pain Observation Tool on pain assessment/management nursing practices in an Intensive Care Unit with nonverbal critically ill adults: A before and after study. *International Journal of Nursing Studies*, 48(12), 1495-1504.

Gélinas C, Fillion L, Puntillo, K. Puntillo, et al. (2006). Validation of the Critical-Care Pain Observation Tool in adult patients. *American Journal of Critical Care*. 15, 420-427.

Hummel, P., Lawlor-Klean, Weiss, MG., (2010). Validity and reliability of the N-PASS assessment tool with acute pain. *Journal of Perinatology*. 30, 474-478.

Hummel, P., Puchalski, M., Creech, S.D., & Weiss, M. (2008). Clinical reliability and validity of the N-PASS: neonatal pain, agitation and sedation scale with prolonged pain. *Journal of Perinatology*, 28, 55-56.

McCaffery M., Herr K., & Pasero C. (2011). Pain Assessment and Pharmacologic Management. St. Louis, MO; Mosby.

Quinn, T. E. (2006). Appropriate use of "Assumed Pain Present" (APP) and the analgesic trial in practice and documentation. Retrieved from http://www2.massgeneral.org/painrelief/use_of_app.pdf.

Walden M., & Gibbins S. (2008). Pain Assessment and Management Guideline for Practice. National Association of Neonatal Nurses. (2nd ed.) Glenview, IL.

The Joint Commission. (2012). PC.01.02.07. The hospital assesses and manages the patient's pain. In: Provision of Care, Treatment and Services. Retrieved from <https://e-edition.jcinc.com/MainContent.aspx>.