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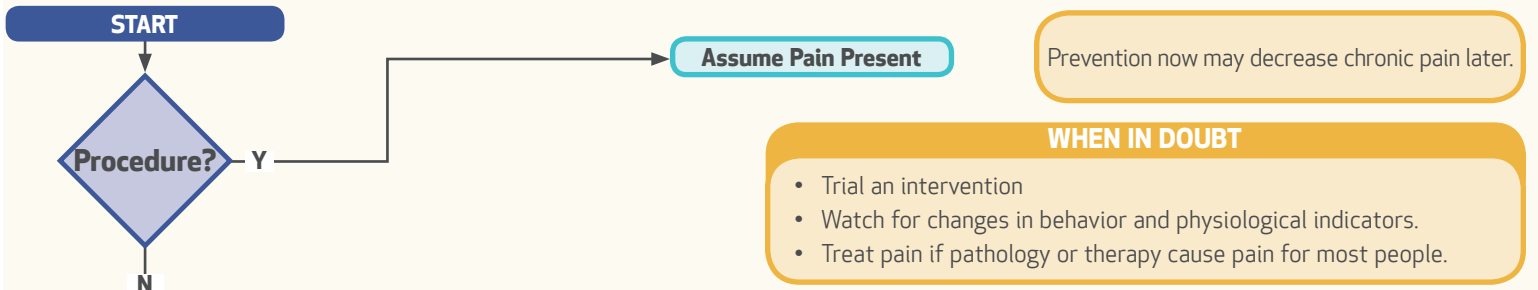
PRINCIPLES OF HIGHLY RELIABLE CARE:

# PAIN ASSESSMENT TOOLS

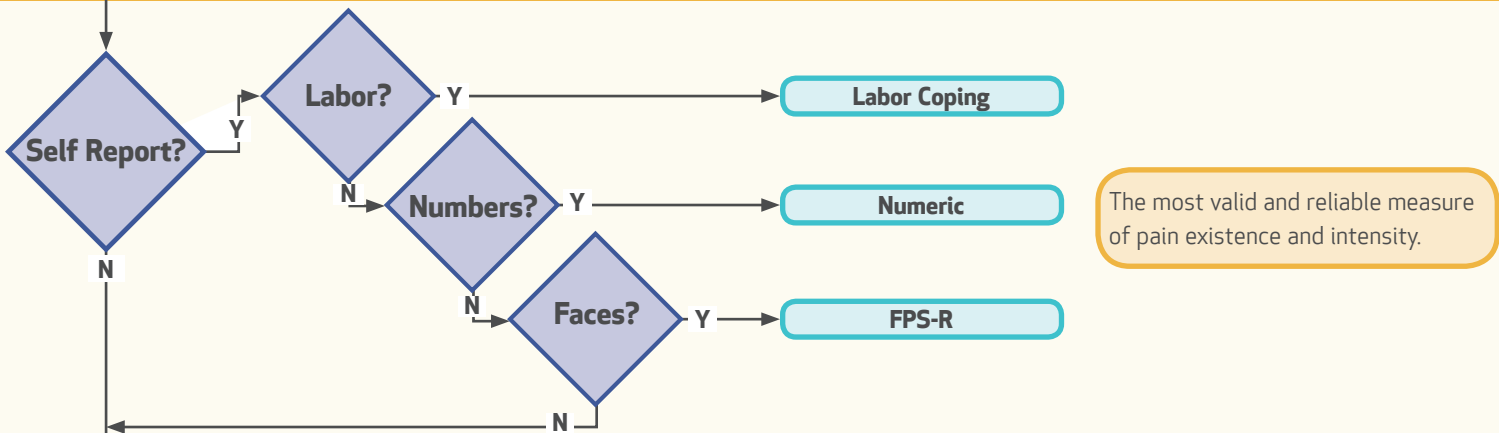
# Pain Assessment Tools Decision Tree

Order code: Decision Tool\_April 2016

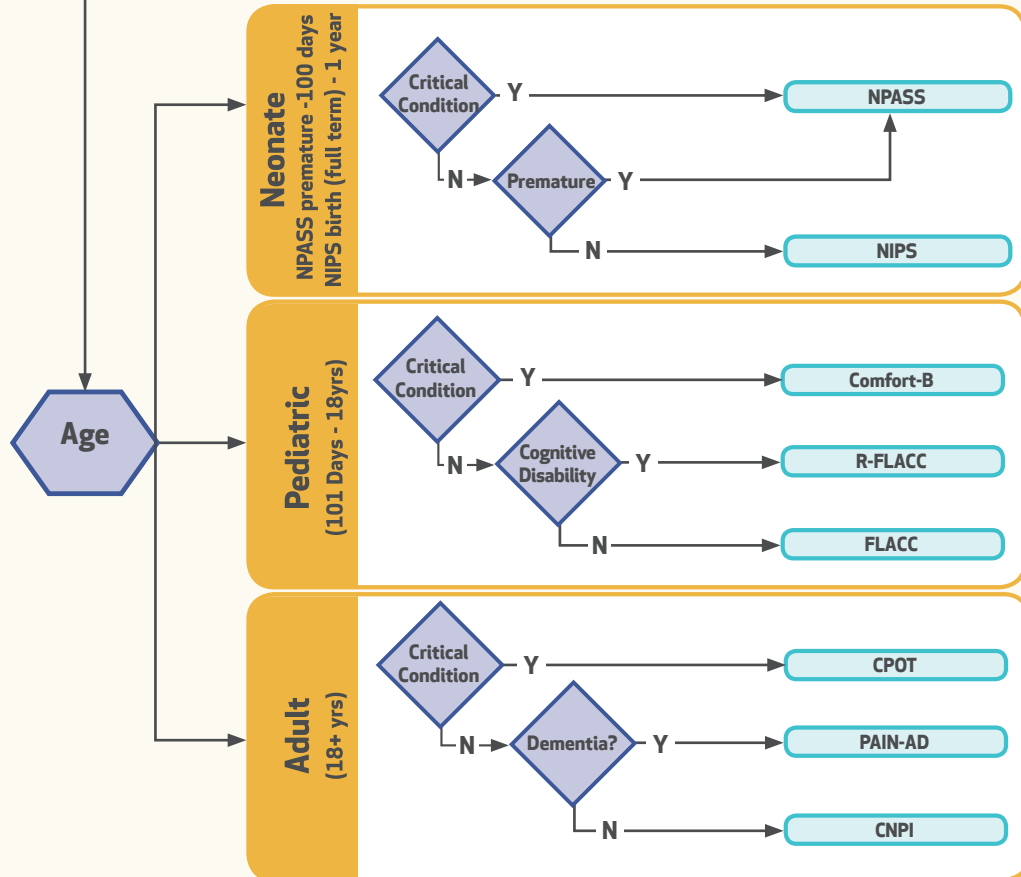
## ANTICIPATE PAINFUL PROCEDURES



## SELF - REPORT: PATIENTS'S DESCRIPTION OF PAIN



## OBJECTIVE BEHAVIORAL ASSESSMENT

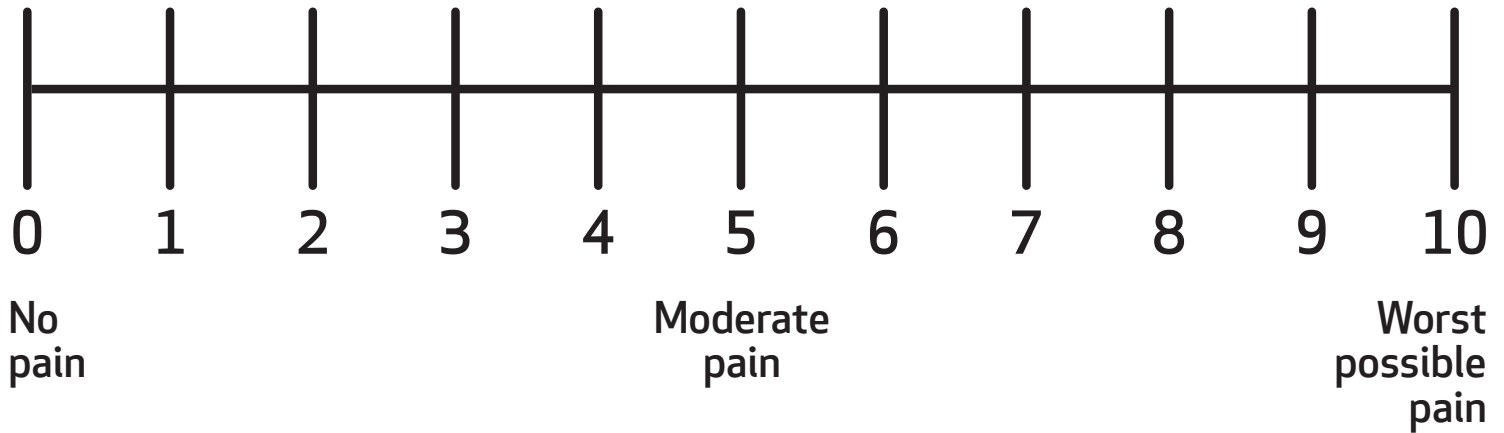


- Behavioral pain tools help to focus on behaviors that are indicators of pain.
- Increasing/decreasing scores using the same tool may suggest increasing/decreasing pain.
- However, behavioral tool scores **cannot** be translated into pain intensity like self-report scores. (i.e., a low behavioral score does not imply low-intensity pain.)
- NIPS and FLACC have overlap coverage and both tools are appropriate between 101 days and one year. Consistency is the most important factor. Stay with the tool that was originally selected to offer the ability to compare results.

# Numeric Pain Rating Scale

Order code: Numeric Tool\_April 2016

This is the gold standard for obtaining a self-reported pain level. This scale may be used in any care setting for patients eight years and older who are able to self-report their pain and understand the numeric scale.



CCC Ref: McCaffery, M., & Beebe, A. (1993). Pain: Clinical Manual for Nursing Practice. Baltimore: V.V. Mosby Company.

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## How to use:

- Ask the patient, "On a scale from 0 to 10 where 0 is no pain and 10 is the worst pain you've experienced, at this moment, what number represents your overall pain level?"
- Patient to select one whole value

## Scoring/Documentation:

- Numeric has a range from 0 to 10 possible.
- Document score in medical record (this includes 0 for no pain).

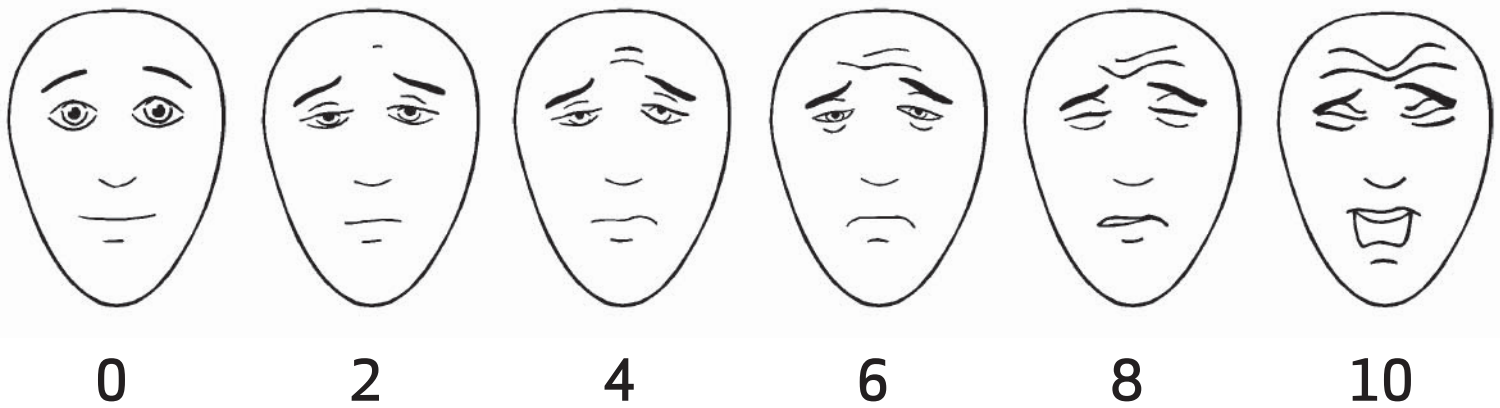
## Interpretation:

- 0 to 3 mild pain
- 4 to 6 moderate pain
- 7 to 10 severe pain
- Compare the patient's acceptable level of pain to the patient's current self-report of pain to determine level of intervention. This may include non-pharmacologic and pharmacologic interventions.
- Reasses patient per frequency of local pain policy.

# Faces Pain Scale-Revised (FPS-R)

Order code: Faces Tool\_April 2016

This self-report pain assessment tool can be used in all care settings, with patients four years and older who can recognize and understand faces.



CCC Ref: Reprinted from Pediatrics Vol. 126 No. 5, Deborah Tomlinson, MN, Carl L. von Baeyer, PhD, Jennifer N. Stinson, PhD, and Lillian Sung, PhD, Systematic Review of Faces Scales for the Self-report of Pain Intensity in Children, page nos. e1168 -e1198, 2010.

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## How to use:

- Show patient faces scale.
- Explain the tool, "These faces show how much something can hurt." Point to zero picture and state, "This one shows no pain." Point to ten picture and state, "This one shows worst pain experienced".
- Ask patient, "What face best represents your pain level right now?"

## Scoring/Documentation:

- Faces Pain Scale-Revised has a range from 0 to 10 possible.
- Document score in medical record; this includes 0 for no pain.

## Interpretation:

- 0 to 3 mild pain
- 4 to 6 moderate pain
- 7 to 10 severe pain
- Compare the patients acceptable level of pain to the patients current self-report of pain to determine level of intervention. This may include non-pharmacologic and pharmacologic interventions.
- Reassess patient per frequency of local pain policy.

# NIPS: Neonatal Infant Pain Scale

Order code: NIPS Tool\_April 2016

Behavior observation pain assessment tool indicated for use with full term newborn to one year of age. Primarily used in OB, pediatric non-ICU areas, ED, pediatric pre-op and post-op surgery.

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
<b>FACIAL EXPRESSION</b>	<b>Relaxed Muscles</b> Restful face, neutral expression	<b>Grimace</b> Tight facial muscles; furrowed brow, chin, jaw, (negative facial expression - nose, mouth and brow)	N/A	
<b>CRY</b>	<b>No Cry</b> Quiet, not crying	<b>Whimper</b> Mild moaning, intermittent	<b>Vigorous Cry</b> Loud scream; rising, shrill, continuous	
<b>BREATHING PATTERNS</b>	<b>Relaxed</b> Usual pattern for this infant	<b>Change in Breathing</b> Indrawing, irregular, faster than usual; gagging; breath holding	N/A	
<b>ARMS</b>	<b>Relaxed/Restrained</b> No muscular rigidity; occasional random movements of arms	<b>Flexed/Extended</b> Tense, straight arms; rigid and/or rapid extension, flexion	N/A	
<b>LEGS</b>	<b>Relaxed/Restrained</b> No muscular rigidity; occasional random leg movements	<b>Flexed/Extended</b> Tense, straight legs; rigid and/or rapid extension, flexion	N/A	
<b>STATE OF AROUSAL</b>	<b>Sleeping/Awake</b> Quiet, peaceful sleeping or alert random leg movement	<b>Fussy</b> Alert, restless, and thrashing	N/A	
<b>TOTAL NIPS SCORE</b>				<b>/7</b>

CCC Ref: Copyright Springer Publishing Company, LLC. Reprinted from Lawrence J, Alcock D, McGrath P, Kay J, MacMurray SB, Dulberg C. The development of a tool to assess neonatal pain. Neonatal Netw 1993 Sep; 12(6): 59-66. With permission.

CCC Ref: Reprinted with Permission from: Lawrence J, Alcock D, McGrath P, Kay J, MacMurray SB, Dulberg C. The development of a tool to assess neonatal pain. Neonatal Netw. 1993 Sept; 12(6):59-66. Copyright Springer Publishing Company, LLC. All rights reserved.)

## How to use:

- Observe the infant for one minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

## Scoring/Documentation:

- Add the scores from the 6 individual behavior areas to generate a total NIPS score.
- NIPS has a range from 0 to 7 possible.
- Document the total NIPS score in the medical record.

## Interpretation:

- Does not provide pain intensity rating
- Any score greater than 2 indicates the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total NIPS score remains >2 consider pharmacologic intervention.

# NPASS: Neonatal Pain, Agitation & Sedation Scale

Order code: NPASS Tool\_April 2016

Behavior observation pain assessment and sedation tool should be used with premature neonates to 100 days of life. This tool is primarily used in the pediatric pre and post-operative area, NICU, PICU and home care. 100 days of life is calculated from date of birth.

BEHAVIOR INDICATORS	SEDATION SCORING	SEDATION		NORMAL/ PAIN	PAIN/AGITATION		PAIN/ AGITATION SCORING
		-2	-1	0/0	1	2	
<b>Crying Irritability</b>		No cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals; Consolable	High-pitched or silent-continuous cry; Inconsolable	
<b>Behavior State</b>		No arousal to any stimuli; No spontaneous movement	Arouses minimally to stimuli; Little spontaneous movement	Appropriate for gestational age	Restless, squirming; Awakens frequently	Arching, kicking; Constantly awake or Arouses minimally no movement (not sedated)	
<b>Facial Expression</b>		Mouth is lax; No expression	Minimal expression with stimuli	Relaxed appropriate	Any pain expression, intermittent	Any pain expression, continual	
<b>Extremities Tone</b>		No grasp reflex; Flaccid tone	Weak grasp reflex; decreased muscle tone	Relaxed hands and feet Normal tone	Intermittent clenched toes, fists or finger splay; Body is not tense	Continual clenched toes, fists, or finger splay; Body is tense	
<b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b>		No variability with stimuli; Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline; SaO <sub>2</sub> 76-85% with stimulation – quick increase	Increase greater than 20% from baseline; SaO <sub>2</sub> less than or equal too 75% with stimulation – slow increase; Out of sync/ fighting vent	
<b>Gestation/ Corrected age</b>	<b>N/A</b>						
<b>TOTAL SEDATION SCORE</b>	<b>/-10</b>					<b>TOTAL PAIN/ AGITATION SCORE</b>	<b>/13</b>

**Premature Pain Assessment**

- +3 if less than 28 weeks gestation/corrected age**
- +2 if less than 28 - 31 weeks gestation/corrected age**
- +1 if less than 32 - 35 weeks gestation/corrected age**

CCC Ref: Reprinted from Journal of Perinatology, 28, P. Hummel, M. Puchalski, SD Creech, and MG Weiss, Clinical reliability and validity of the N-PASS: neonatal pain, agitation and sedation scale with prolonged pain, 55-60, 2008. Reproduced with permission from copyright holder.

CCC Ref: Reprinted from American Academy of Pediatrics, 132(1), P Deindl, L. Unterasinger, G Kappler, T. Werther, C. Czaba, V. Giordano, S. Frantal, A. Berger, A. Pollak and M. Olischar, Successful Implementation of Neonatal Pain and Sedation Protocols at 2 NICUs, e1- e8, 2013. Reproduced with permission from copyright holder.

Sedation Protocols at 2 NICUs, e1- e8, 2013. Reproduced with permission from copyright holder.

# NPASS: Neonatal Pain, Agitation & Sedation Scale

Order code: NPASS Tool\_April 2016

	SEDATION	PAIN/AGITATION
How to Use	<ul style="list-style-type: none"> <li>• Sedation does not need to be assessed/scored with every pain assessment</li> <li>• Observe the infant for a minute before selecting a score for each behavior.</li> <li>• Select only one numeric value per behavior.</li> </ul>	<ul style="list-style-type: none"> <li>• Observe the infant for a minute before selecting a score for each behavior.</li> <li>• Select only one numeric value per behavior.</li> </ul>
Scoring/Documentation	<ul style="list-style-type: none"> <li>• Sedation scores are negative scores only</li> <li>• Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age)</li> <li>• NPASS Sedation total score has a range from 0 to -10 possible.</li> <li>• Document total NPASS Sedation score in the medical record.</li> </ul>	<ul style="list-style-type: none"> <li>• Pain/Agitation scores are positive scores only</li> <li>• Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria.</li> <li>• Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score.</li> <li>• NPASS Pain/Agitation total score has a range from 0 to 13 possible.</li> <li>• Document the total NPASS Pain/Agitation score in the medical record</li> </ul>
Interpretation	<ul style="list-style-type: none"> <li>• Desired levels of sedation vary according to the situation.</li> <li>• Discuss and determine sedation goal with provider.               <ul style="list-style-type: none"> <li>• "Deep sedation": goal score of -10 to -5                   <ul style="list-style-type: none"> <li>• Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea</li> </ul> </li> <li>• "Light sedation": goal score of -5 to -2</li> </ul> </li> <li>• Reassess patient per frequency in local sedation policy               <ul style="list-style-type: none"> <li>• A negative score without the administration of opioids/ sedatives may indicate:                   <ul style="list-style-type: none"> <li>• The premature infant's response to prolonged or persistent pain/stress</li> <li>• Neurologic depression, sepsis, or other pathology</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Does not provide pain intensity rating.</li> <li>• Any score greater than 3 indicates the possibility of the presence of pain in the infant               <ul style="list-style-type: none"> <li>• Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological).</li> <li>• Reassess patient per frequency of local pain policy.</li> <li>• If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.</li> </ul> </li> </ul>

## Paralysis/Neuromuscular blockade

- It is impossible to evaluate behaviorally a paralyzed infant for pain.
- Infants will usually have a sedation score of -10.
- Increases in heart rate and blood pressure at rest or with stimulation may be the only indicator for a need of more analgesia.

# FLACC: Face, legs, activity, cry and consolability

Order code: FLACC Tool\_April 2016

Behavior observation pain assessment tool indicated for use with infants 2 months to 18 years of age who are unable to self-report their pain. This tool is used primarily in pediatric non-ICU areas, ED, pediatric pre-op and post-op surgery, and home care.

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
<b>FACE</b>	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw	
<b>LEGS</b>	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up	
<b>ACTIVITY</b>	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking	
<b>CRY</b>	No cry, (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints	
<b>CONSOLABILITY</b>	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractable	Difficulty to console or comfort	
<b>TOTAL FLACC SCORE</b>				<b>/10</b>

CCC Ref: © 2002, The Regents of the University of Michigan. Original validation – Merkel, S. Voepel-Lewis T. Shayevitz J. & Malviya S. The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing* 1997, 23:293-297

## How to use:

- Observe the patient for a minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

## Scoring/Documentation:

- Add the scores from the 5 individual behavior areas to generate a total FLACC score.
- FLACC has a range from 0 to 10 possible.
- Document total FLACC in the medical record.

## Interpretation:

- Does not provide pain intensity rating
- Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total FLACC score remains consistent or higher consider pharmacologic intervention.



# R-FLACC: Revised face, legs, activity, cry and consolability

Order code: rFLACC Tool\_April 2016

Behavior observation pain assessment tool indicated for use with infants 2 months to 18 years of age with a cognitive disability and is unable to self-report their pain. Used primarily in pediatric non-ICU areas, ED, pediatric pre-op and post-op surgery, PICU and home care.

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
<b>FACE</b>	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, <b>sad appears worried</b>	Frequent to constant quivering chin, clenched jaw, <b>distressed looking face, expression of fright/panic</b>	
<b>LEGS</b>	Normal position or relaxed, <b>usual tone &amp; motion to limbs</b>	Uneasy, restless, tense, <b>occasional tremors</b>	Kicking, or legs drawn up, <b>marked increase in spasticity, constant tremors, jerking</b>	
<b>ACTIVITY</b>	Lying quietly, normal positions moves easily, <b>regular, rhythmic respirations</b>	Squirming, shifting back and forth, tense, <b>tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs</b>	Arched, rigid or jerking, <b>severe agitation, head banging, shivering, breath holding, gasping, severe splinting</b>	
<b>CRY</b>	No cry, (awake or asleep)	Moans or whimpers; occasional complaint, <b>occasional verbal outbursts, and/or grunting</b>	Crying steadily, screams or sobs, frequent complaints, <b>repeated outbursts, constant grunting</b>	
<b>CONSOLABILITY</b>	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractable	Difficulty to console or comfort, <b>pushing caregiver away, resisting care or comfort measures</b>	
<b>TOTAL R-FLACC SCORE</b>				<b>/10</b>

CCC Ref: © 2002, The Regents of the University of Michigan. Revised FLACC validation – Malviya S, Voepel-Lewis T, Burke CN, Merkel S, Tait AR. The revised FLACC observational pain tool: Improved reliability and validity for pain assessment in children with cognitive impairment. Pediatric Anesthesia 2006; 16:258-65.

## How to use:

- Observe the patient for a minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

## Scoring/Documentation:

- Add the scores from the 5 individual behavior areas to generate a total R-FLACC score.
- R-FLACC has a range from 0 to 10 possible.
- Document the total R-FLACC in the medical record

## Interpretation:

- Does not provide pain intensity rating
- Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions. Partner with patient's caregivers to identify appropriate interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total R-FLACC score remains consistent or higher consider pharmacologic intervention.

# COMFORT B: COMFORT Behavior

Order code: COMFORT-B Tool\_April 2016

Behavior observation pain assessment and sedation tool indicated for use with neonates greater than 100 days of life to 18 years of age with a cognitive disability and is unable to self-report their pain, used primarily in NICU and PICU.

BEHAVIOR INDICATORS	SCORING DESCRIPTION					SCORE
	1	2	3	4	5	
<b>ALERTNESS</b>	Deep asleep (eyes closed, no response to change in environment)	Lightly asleep (eyes mostly closed, occasional response)	Drowsy (child closes his/her eyes frequently, less responsive to environment)	Awake and alert (child responsive to environment)	Awake and hyper-alert (exaggerated responses to environmental stimuli)	
<b>CALMNESS/AGITATION</b>	Calm (child appears serene and tranquil)	Slightly anxious (child shows slight anxiety)	Anxious (child appears agitated but remains in control)	Very anxious (child appears very agitated, just able to control)	Panicky (severe distress with loss of control)	
<b>RESPIRATORY RESPONSE</b> (Score only in mechanically ventilated children)	No spontaneous respiration	Spontaneous and ventilator respiration	Restlessness or resistance to ventilator	Actively breathes against ventilator or coughs regularly	Fight ventilator	
<b>OR</b>						<b>OR</b>
<b>CRYING</b> (Score only in spontaneously breathing children)	Quietly breathing, no crying sounds	Occasional sobbing or moaning	Whining (monotonous sound)	Crying	Screaming or shrieking	
<b>PHYSICAL MOVEMENT</b>	No movement	Occasional (three or fewer) slight movements	Frequent (more than three) slight movements	Vigorous movements limited to extremities	Vigorous movements including torso and head	
<b>MUSCLE TONE</b> (Assess last)	Muscles totally relaxed, no muscle movement	Reduced muscle tone, less resistance than normal	Normal muscle tone	Increased muscle tone and flexion of fingers and toes	Extreme muscle rigidity and flexion of fingers and toes	
<b>FACIAL TENSION</b>	Facial muscles totally relaxed	Normal facial tone	Tension evident in some facial muscles (not sustained)	Tension evident throughout facial muscles (sustained)	Facial muscles contorted and grimacing	
<b>TOTAL COMFORT B SCORE</b>						<b>/30</b>

# COMFORT B: COMFORT Behavior

Order code: COMFORT-B Tool\_April 2016

## How to use:

- Observe the patient for two minutes before selecting a score for each behavior.
- Select only one numeric value per behavior.
- Muscle tone should be assessed last as this requires active intervention by the clinician and can alter the other behavior responses.
- If the patient is ventilated assess for respiratory response. If the patient is not ventilated assess for crying.

## Scoring/Documentation

- Add the scores from the 6 individual behavior areas to generate a total COMFORT B score.
- COMFORT B has a range from 6 to 30 possible.
- Document the highest numeric value behavior observed during the two minutes and the total COMFORT B score in the medical record.

## Interpretation:

- **Pain:**
  - Does not provide pain intensity rating
  - Any score greater than or equal to 17 indicates the possibility of the presence of pain in the patient:
    - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
    - Re-assess patient per frequency of local pain policy.
    - If upon reassessment the total COMFORT B score remains consistent or higher consider pharmacologic intervention.
- **Sedation:**
  - Discuss patient goal with provider to determine sedation strategy:
    - A score of 6 to 10 indicates over sedation
    - A score of 11 to 23 indicates moderate sedation
    - A score of 24 to 30 indicates under sedation

# CNPI: Checklist of Nonverbal Pain Indicators

Order code: CNPI Tool\_April 2016

Behavior observation pain assessment tool indicated for use with adults 18 years of age and up with a cognitive disability and is unable to self-report their pain. This tool is used primarily in adult non intensive care settings, Senior Living and home care.

**0 = NOT OBSERVED | 1 = OBSERVED WITH MOVEMENT AND/OR AT REST**

BEHAVIOR INDICATORS	WITH MOVEMENT	AT REST
1. <b>Vocal complaints; nonverbal</b> (Sighs, gasps, moans, groans, cries)		
2. <b>Facial Grimaces/Winces</b> (Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop, distorted expressions)		
3. <b>Bracing</b> (Clutching or holding onto furniture, equipment, or affected area during movement)		
4. <b>Restlessness</b> (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)		
5. <b>Rubbing</b> (Massaging affected area)		
6. <b>Vocal complaints; verbal</b> (Words expressing discomfort or pain [e.g., "ouch," "that hurts"]; cursing during movement; exclamations of protest [e.g., "stop," "that's enough"])		
<b>SUBTOTAL SCORES</b>	<b>+</b>	
<b>TOTAL CNPI SCORE (ADD BOTH SUB TOTALS)</b>		<b>/12</b>

CCC Ref: Reprinted from Journal of Clinical Nursing, 24, Li-Li Guo, Li Li, Yao-Wei Liu and Keela Herr, Evaluation of two observational pain assessment scales during the anaesthesia recovery period in Chinese surgical older adults, 212 – 221, 2015. Reproduced with permission from copyright holder.

## How to use:

- Observe the patient for a minute at both rest and during movement before selecting a score for each behavior.
- Select only one numeric value per observed behavior with movement and at rest.

## Scoring/Documentation:

- Add the scores from the 6 individual behavior areas of at rest and with movement to generate a total CNPI score.
- CNPI has a range from 0 to 12 possible.
- Document total CNPI score in the medical record.


## Interpretation:

- Does not provide pain intensity rating
- Any score between 1 and 12 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions. Partner with patient's caregivers to determine appropriate interventions.
- Re-assess patient per frequency of local pain policy.
- If upon reassessment the total CNPI score remains consistent or higher consider pharmacologic intervention.

# CPOT: Critical-Care Pain Observation Tool

Order code: CPOT Tool\_April 2016

Behavior observation pain assessment tool indicated for use with adult patients 18 years of age and older who is unable to self-report their pain, and is used primarily in the Adult ICU setting and home care.

BEHAVIOR INDICATORS	SCORING DESCRIPTION		SCORE
<b>Facial expressions</b>  Relaxed, neutral 0   Tender 1   Grimacing 2	Relaxed, neutral	0 No muscle tension observed	
	Tense	1 Presence of frowning, brow lowering, orbit tightening and levator contraction, or any other change (e.g., opening eyes or tearing during nociceptive procedures)	
	Grimacing	2 All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)	
<b>Body movements</b>	Absence of movements or normal position	0 Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)	
	Protection	1 Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements	
	Restlessness	2 Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed	
<b>Compliance with the ventilator (intubated patients)</b>	Tolerating ventilator or movement	0 Alarms not activated, easy ventilation	
	Coughing but tolerating	1 Coughing, alarms may be activated but stop spontaneously	
	Fighting ventilator	2 Asynchrony: blocking ventilation, alarms frequently activated	
<b>OR</b>			
<b>Vocalization (extubated patients)</b>	Talking in normal tone or no sound	0 Talking in normal tone or no sound	
	Sighing, moaning	1 Sighing, moaning	
	Crying out, sobbing	2 Crying out, sobbing	
<b>Muscle tension (Assess last)</b> <b>Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned</b>	Relaxed	0 No resistance to passive movements	
	Tense, rigid	1 Resistance to passive movements	
	Very tense or rigid	2 Strong resistance to passive movements, incapacity to complete them	
<b>TOTAL CPOT SCORE</b>			<b>/8</b>

# CPOT: Critical-Care Pain Observation Tool

Order code: CPOT Tool\_April 2016

## How to use:

- Observe the patient for a minute before selecting a score for each behavior.
- Muscle tension should be assessed last as this requires active intervention by the clinician and can alter the other behavior responses.
- Select only one numeric value per behavior.
- If the patient is ventilated assess for compliance with the ventilator. If the patient is not ventilated assess for vocalization.

## Scoring/Documentation:

- Add the scores from the 5 individual behavior areas to generate a total CPOT score.
- CPOT has a range from 0 to 8 possible.
- Document the highest numeric value behavior observed during the minute and the total CPOT score in the medical record.

## Interpretation:

- Does not provide pain intensity rating
- Any score between 1-8 indicates the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and/or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total CPOT score remains consistent or higher consider pharmacologic intervention.

# PAIN-AD: Pain Assessment in Advanced Dementia

Order code: PAIN-AD Tool\_April 2016

Behavior observation pain assessment tool indicated for use with adult patients 18 years of age and older, with a diagnosis of dementia and is unable to self-report their pain. This tool is used primarily in ED, adult pre-op and post-op surgery, adult ICU, Adult non-ICU, Senior Living, home care and the provider's office.

BEHAVIOR INDICATORS	SCORING DESCRIPTION			SCORE
	0	1	2	
<b>Breathing Independent of vocalization</b>	Normal	<ul style="list-style-type: none"> <li>Occasional labored breathing</li> <li>Short period of hyperventilation</li> </ul>	<ul style="list-style-type: none"> <li>Noisy labored breathing</li> <li>Long period of hyperventilation</li> <li>Cheyne-Stokes respirations</li> </ul>	
<b>Negative vocalization</b>	None	<ul style="list-style-type: none"> <li>Occasional moan or groan</li> <li>Low-level speech with a negative or disapproving quality</li> </ul>	<ul style="list-style-type: none"> <li>Repeated troubled calling out</li> <li>Loud moaning or groaning</li> <li>Crying</li> </ul>	
<b>Facial expression</b>	Smiling or inexpressive	<ul style="list-style-type: none"> <li>Sad</li> <li>Frightened</li> <li>Frown</li> </ul>	<ul style="list-style-type: none"> <li>Facial grimacing</li> </ul>	
<b>Body language</b>	Relaxed	<ul style="list-style-type: none"> <li>Tense</li> <li>Distressed pacing</li> <li>Fidgeting</li> </ul>	<ul style="list-style-type: none"> <li>Rigid</li> <li>Fists clenched</li> <li>Knees pulled up</li> <li>Pulling or pushing away</li> <li>Striking out</li> </ul>	
<b>Consolability</b>	No need to console	<ul style="list-style-type: none"> <li>Distracted or reassured by voice or touch</li> </ul>	<ul style="list-style-type: none"> <li>Unable to console, distract, or reassure</li> </ul>	
<b>TOTAL PAIN-AD SCORE</b>				<b>/10</b>

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## How to use:

- Observe the patient for a minute before selecting a score for each behavior.
- Select only one numeric value per behavior.

## Scoring/Documentation:

- Add the scores from the 5 individual behavior areas to generate a total PAIN-AD score.
- PAIN-AD has a range from 0 to 10 possible.
- Document total PAIN-AD in the medical record.

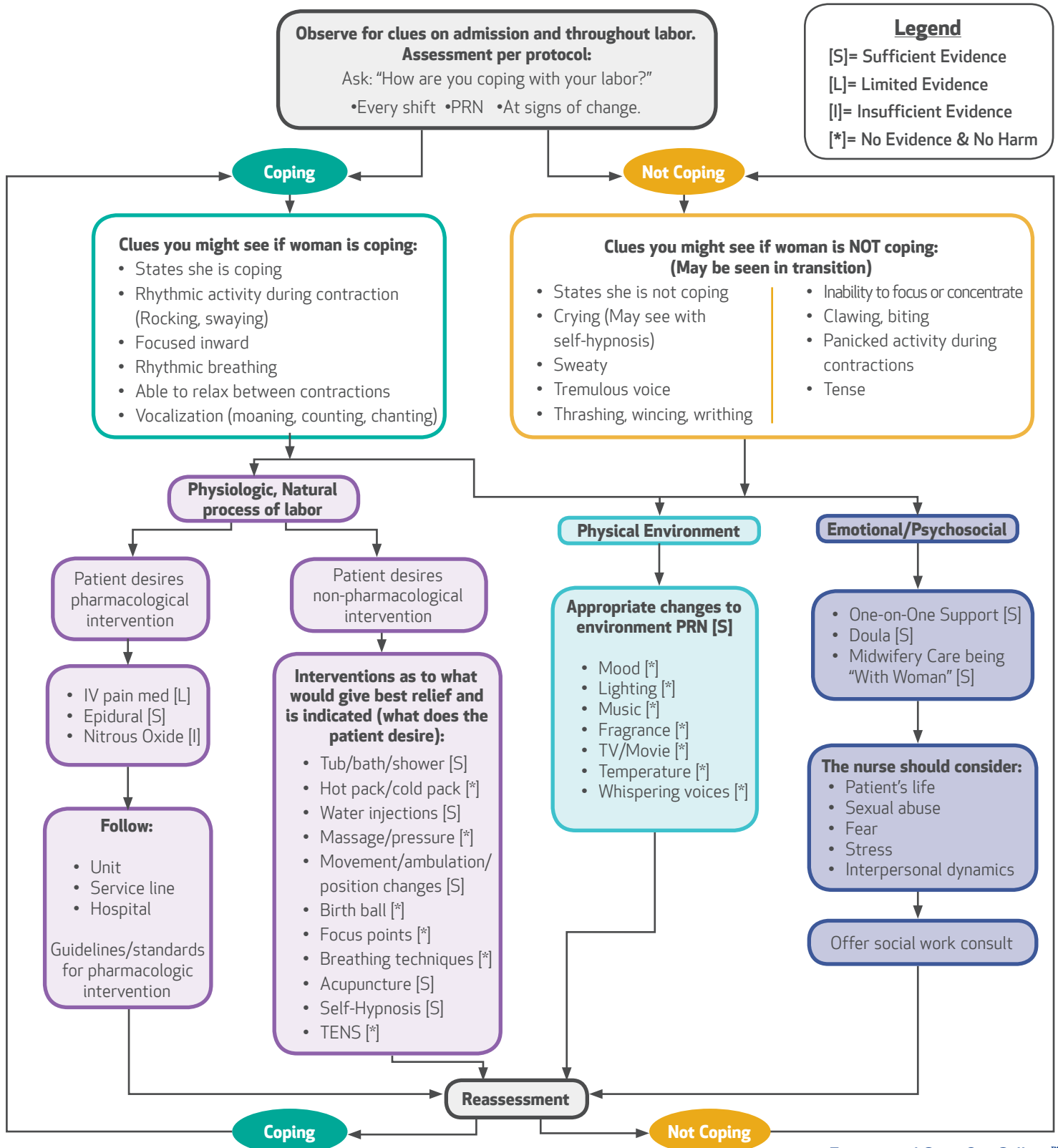
## Interpretation:

- Does not provide pain intensity rating
- Any score between 1 and 10 can indicate the possibility of the presence of pain in the patient:
  - Continue evaluation to identify the potential source of pain and implement appropriate non-pharmacologic and /or pharmacologic interventions.
  - Re-assess patient per frequency of local pain policy.
  - If upon reassessment the total PAIN-AD score remains consistent or higher consider pharmacologic intervention.

# Coping with Labor Algorithm<sub>v2</sub>

Order code: Coping Tool\_April 2016

It is expected that laboring women will experience pain. Therefore asking the patient their pain level is frustrating and confusing. The coping with Labor Algorithm focuses on how laboring women are coping via self-reporting and observation. This is to be used on laboring women only primarily in the OB area.





# Coping with Labor Algorithm<sub>v2</sub>

Order code: Coping Tool\_April 2016

## How to use: There are 2 areas to assess:

- Woman's self-report of coping: Ask patient, "How are you coping with your labor?"<sup>41</sup>
- Clinician observation of coping: Observe the woman for visual clues demonstrating coping or not coping (as noted on previous page)

## Scoring/Documentation:

- Document the woman's self-report of coping: "states coping" or "states not coping"
- Document the clinician observation of coping: "demonstrates/observed coping behavior" or "demonstrates/observed non-coping behavior"
- Document all interventions in the medical record.

## Interpretation:

- If the clinician identifies that a woman is not coping there are 3 levels of interventions available, physiologic, physical environment and emotional/psychosocial (as noted on previous page).
- Obtain patient's preferences, demonstrated behaviors and available treatment options to determine potential interventions.
- There is no limit to the number of interventions to utilize, nor a requirement to select from each category. It is up to the needs and requests of the laboring woman.
- Re-assess patient per frequency of local pain policy.

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