

# 1 Pain Clinical Reminders Main Menu

Clinical Reminders for pain have been divided into four areas:

1. Clinician/providers
2. Nursing
3. All clinical staff
4. Web links

Assessments, plans of care, and reassessments reminders/ templates are provided for clinician/ provider groups and nursing groups separately. (For those facilities where state law or facility Scope of Practice does not permit LPNs or nursing assistants to conduct assessments, a separate reminder to provide “observations and re-observations” is included to comply with these regulations while still allowing LPNs and NAs to work with pain patients.)

Each reminder can be separated out and installed individually, arranged as facility pain and informatics workgroups determine to be most suitable. As written, these reminders may assist in meeting Joint Commission standards and providing quality care to veterans in pain.

Most of the reminder sections are not designed with health factors already included, as each facility may already have defined health factors for pain.

**Reminder Resolution: TEST PAIN SCREEN**

PAIN MANAGEMENT MAIN MENU

CLINICIANS

- Complete a CLINICIAN COMPREHENSIVE PAIN ASSESSMENT/PAIN HISTORY
- Complete a CLINICIAN PAIN REASSESSMENT & PAIN CARE PLAN
- Complete a COGNITIVELY IMPAIRED ASSESSMENT/REASSESSMENT & PAIN PLAN OF CARE
- Complete a CLINICIAN POST-OPERATIVE PAIN ASSESSMENT/REASSESSMENT
- Monitor OPIOID THERAPY

NURSING

- Complete a NURSING (RN) PAIN ASSESSMENT & PAIN CARE PLAN
- Complete a NURSING (RN) PAIN REASSESSMENT & PAIN CARE PLAN
- Complete a NURSING (RN) COGNITIVELY IMPAIRED ASSESSMENT/REASSESSMENT
- Complete a NURSING (LPN/NA) PAIN OBSERVATION/REOBSERVATION

APPLICABLE TO ALL

- Record a NUMERIC PAIN SCORE
- Complete PATIENT PAIN EDUCATION

[LINK to Pain Clinical Practice Guidelines](#)

[LINK to VA Pain Management Website](#)

To open any reminder in the pain menu, click on the box. CACs may want to install the reminders individually in order to make reminders available to only certain clinical services.

## 2 Clinician Assessment and Pain History

This reminder template can be used by Primary Care and specialty care providers, generally for initial pain assessments. It has been designed by pain experts to be comprehensive and compatible with features regularly used in CPRS.

**Reminder Resolution: TEST PAIN SCREEN**

MAIN MANAGEMENT MAIN MENU

CLINICIANS

Complete a CLINICIAN COMPREHENSIVE PAIN ASSESSMENT/PAIN HISTORY

CURRENT LEVEL OF PAIN (Updates Vital Sign package): If 0 is no pain and 10 is the worst pain imaginable what is your current level of pain?

1 - slightly uncomfortable

Action required: \_\_\_\_\_

USUAL LEVEL OF PAIN: What is your usual level of pain? (How does your pain feel most of the time?)

Comment: \_\_\_\_\_

0  1  2  3  4  5  6  7  8  9  10

LEAST LEVEL OF PAIN: What is your least level of pain? (What is the lowest level of pain you feel?)

Comment: \_\_\_\_\_

0  1  2  3  4  5  6  7  8  9  10

ACCEPTABLE LEVEL OF PAIN: If you had to live with some pain, what level of pain would be acceptable?

Comment: \_\_\_\_\_

0  1  2  3  4  5  6  7  8  9  10

Clicking on Clinician Comprehensive Pain Assessment / Pain History opens the reminder template.

Entering a current level of pain inserts the 0-10 score in the Vitals Package.

Asking patients about usual levels of pain is probably a better indicator of actual pain (as pain scores are often higher during medical visits) experienced regularly—particularly if the patient keeps a pain journal.

Least level of pain gives some indication of how interventions are working.

Acceptable level of pain gives some idea of the patient's goals in treatment.

PAIN LOCATION(S): (Check all that apply)

- Abdomen
- Arm
- Buttocks
- Chest
- Face
- Foot
- Full Body
- General Joint Pain
- Generalized Muscle Pain
- Genitalia
- Hand
- Head/Headache
- Hips
- Knee
- Leg
- Lower Back
- Mouth/Dental Pain
- Neck
- Rectum

The reminder now allows recording of pain in multiple sites without having to complete the entire template for each area of pain.

- Shoulder
- Stomach
- Upper Back
- Wrist
- Other pain

Ask the patient to describe his /her pain first. If unable to verbalize sensations accurately, list can be read to the patient. Multiple qualities can be entered.

QUALITY OF PAIN - How does your pain feel?

- \*  Aching  Burning/Hot  Cramping  Crushing  Dull  Gnawing
- Heavy  Knifelike  Nagging  Numb  Pinching  Pressure  Pricking
- Pulling  Sharp  Shooting  Sickening  Sore  Splitting
- Stabbing  Tender  Throbbing  Tight  Tingling

Month & year are generally known. If date is not, enter "1" for the first of the month.

ONSET AND CAUSE OF PAIN:

ONSET OF PAIN: Date: \* [ ] [ ] 2007 [ ] [ ]

CAUSE OF PAIN: What caused you to have pain to begin with?  
\* [ ]

Cause of pain is a free text box. If patient is uncertain, enter "unknown."

Constant, intermittent, diurnal variations. Free text in comment box for clarification.

CONSISTENCY OF PAIN:

- \*  The pain is always present.  The pain comes and goes.
- The pattern of pain varies.

[Free text comment box]

Most chronic pain patients know what lessens their pain. Multiple methods can be checked off, and may help determine treatment.

ALLEVIATING FACTORS: What makes the pain better?

- Assistive devices (cane, wheelchair)  Brace/
- Chiropractic intervention  Cold  Distraction techniques  Exercise
- Food  Heat  Laying down  Massage  Medications
- Meditation/prayer  Music  Relaxation techniques  Special mattress
- Sleep  Standing  TENS Unit application  Walking
- No identified relief factors

(Specify which factors correspond to which pain complaint in field below)

[Free text comment box]

New to this reminder. Factors not specified can be entered in the free text comment boxes.

AGGRAVATING FACTORS: What makes the pain worse?:

- Bending  Changes in temperature  Changing position  Coughing
- Deep breathing  Exercise  Lifting  Lying Down  Sitting
- Sneezing  Standing  Stress  Walking  Weather
- No identified triggers

(Specify which factors correspond to which pain complaint in field below)

[Free text comment box]

EFFECTS OF PAIN: What aspects of your life have changed as a result of your pain? (select all that apply)

- Anxiety  Appetite  Concentration  Depression  Energy level
- Enjoyment of life  Household chores  Memory  Mobility  Mood
- Personal care  Physical activity  Relationship with others
- Self esteem  Sexual functioning  Sleep  Social activities
- Temper  Work  No effect on activity

Unlisted "effect" can be free-texted in comment box.

PRESCRIPTION MEDICATIONS: Are you taking any prescription medications for your pain?

Active Outpatient Medications (including Supplies):

No Medications Found

None

YES:

RX:

SYMPTOMS RELATED TO PAIN MEDICATIONS: Are you having any symptoms related to medication you are taking for pain?

All active outpatient meds from CPRS will drop in here. Pain meds can be chosen from list of all meds and copied to text box.

OVER-THE-COUNTER MEDICATIONS: Are you taking any over-the-counter medications? Any herbal, natural, or home remedies?

None

OTC:

OTC meds are free text entered here.

Record PHYSICAL EXAM OR DIAGNOSTIC TEST RESULTS

Physical exam results:

Diagnostic test results:

Free text area for PE results

As so many lab and radiology test reports are often not related to the pain condition, the entire lists will not be dropped into this reminder template. Appropriate tests can be added here.

### 3 Clinician Reassessment and Plan of Care

Clinician reassessments are critical to pain patient care. The frequency of reassessments is likely determined by facility policy.

What is an "acceptable" level of pain to the patient will be determined and documented in the initial pain assessment and/or facility policy.

Complete a CLINICIAN PAIN REASSESSMENT & PAIN CARE PLAN

Continue current plan of care - pain scores within acceptable range per patient. Current pain score: 0 (06/16/2004 09:04)

REASSESSMENT of Pain needed due to UNACCEPTABLE pain scores per patient. Current Pain score: 0 (06/16/2004 09:04)

DURING THE PAST WEEK:

What was the patient's AVERAGE level of pain? (0=No pain, 10=Extreme pain) 0

What was the patient's LOWEST level of pain? (0=No Pain, 10=Extreme Pain) 0

What was the patient's pain level after taking their current pain medication(s)? (0=No pain, 10=Extreme pain) 0

How much has pain interfered with the patient's MOOD (depression, anxiety, irritability)? (0=No Interference, 10=Extreme Interference) 0

How much has pain interfered with the patient's SLEEP? (0=No Interference, 10=Extreme Interference) 0

How much has pain interfered with the patient's RELATIONSHIPS WITH FAMILY AND FRIENDS? (0=No Interference, 10=Extreme Interference) 0

How much has pain interfered with the patient's WORK, CHORES, OR HOBBIES? (0=No Interference, 10=Extreme Interference) 0

How much has pain interfered with the patient's ABILITY TO WALK? (0=No Interference, 10=Extreme Interference) 0

How much has pain interfered with the patient's ENJOYMENT OF LIFE? (0=No Interference, 10=Extreme Interference) 0

How much has pain interfered with the patient's SEXUAL FUNCTIONING? (0=No Interference, 10=Extreme Interference) 0

Responses to these questions should assist in treatment planning.

Responses to these questions may assist in making appropriate consultation requests to Mental Health, Physical, Occupational, and Recreation Therapies, as well as to sleep and sexual dysfunction clinics.

- QUALITY & LOCATION OF PAIN:
  - No change in quality or location of pain
  - Change in the quality or location of pain
- COMPLIANT/NONCOMPLIANT WITH CURRENT PAIN PLAN:
  - Complied with the current pain plan or care.
  - NONcompliant with current pain plan of care

Changes may indicate a new pain, an increase in disease, or that the treatment plan is appropriate.

May suggest that it is time to change the treatment plan or to make appropriate consultation requests.

Comment:

IMPROVED FUNCTION (ABILITY TO DO DAILY ACTIVITIES, ETC.)

Comment:

- MEDICATION REVIEW:
  - Renew current prescription(s) (Add local quick order)
  - Change needed to current prescription(s) (add local quick order)
  - Inititiate new prescription needed

Increases/decreases in current medications and/or adding adjuvants.

THERE IS NEW PAIN ASSOCIATED WITH THE CHRONIC PAIN

OTHER COMMENTS RELATED TO REASSESSMENT:  
Comment:

If a new pain is identified, a free-text note may be written here to indicate that a full assessment of the new pain will be completed.

Complete a CLINICIAN PAIN PLAN OF CARE:

- Referrals Initiated To:
- Medications Dispensed:
- Initiate diagnosis test(s) and/or procedure(s):
- Reevaluate pain plan after test(s) have been completed:
- Comments related to pain plan of care:

To services noted earlier

New tests / procedures

Free text box for any additional plan of care items not mentioned in reminder.

## CR 4 Clinician Assessment/ Reassessment Cognitively Impaired

There is no validated instrument to assess pain in patients with significant cognitive impairment or communication difficulty. Some patients with milder impairments are able to use the Wong-Baker (Faces) or visual analog scales. The following reminder template may be used with pain patients with chronic or acute communication or cognitive impairments

The assessment descriptors do not add up to a 0-10 score intentionally. To indicate that an assessment or reassessment has been completed, it is recommended that a score of "99" is entered in the Vitals Package—in order to document that reassessment policy has been adhered to. Patients who do not state their 0-10 pain score (or point to it on a visual scale) cannot have a 0-10 score entered in the Vitals Package.

**Reminder Resolution: TEST PAIN SCREEN**

Complete a COGNITIVELY IMPAIRED ASSESSMENT/REASSESSMENT & PAIN PLAN OF CARE

Patient's failure to report pain should not be taken to mean absence of pain. Persons with severe cognitive impairment frequently under-report pain.

Patients with milder impairment can often learn to use the 0-10 NRS. However, persons with moderate to severe impairments are not likely to be able to use this scale reliably, even with practice.

The same pain assessment method should be used consistently across assessments for each patient. Consider problem behaviors as possible signs of pain or other unmet treatment needs, even if they are not new behaviors.

ASSESSMENT/REASSESSMENT SOURCES (CHECK ALL USED. USE ALL AVAILABLE)

- Patient report
- Family report
- Clinical observation of behaviors

PHYSICAL FINDINGS ARE CONSISTENT WITH PAIN

Comment:

It is critical that the same assessment method be used for each reassessment in order to note changes in behaviors (suggesting a change in pain.) The same scales appear in the RN and LPH/NA reminders.

Some pain research suggests that families tend to over-estimate a patient's pain, and that clinicians tend to under estimate it in cognitively impaired patients.

Physical findings such as arthritic swelling can be entered here.

BEHAVIORS THAT MAY INDICATE THE PRESENCE OF PAIN:

AT REST: (CHECK ALL THAT APPLY):

- Patient verbalizes presence of pain
- Facial expressions of discomfort/distress
- Vocalizations (e.g. grunting, groaning, crying, sighing)
- Postural guarding (e.g. bracing, holding body part)
- Restlessness (e.g. repetitive movement, writhing)
- Other:

WITH MOVEMENT: (CHECK ALL THAT APPLY):

- Patient verbalizes presence of pain
- Facial expressions of discomfort/distress
- Vocalizations (e.g. grunting, groaning, crying, sighing)
- Restlessness (e.g. repetitive movement, writhing)
- Reluctance to move or to being moved
- Other:

OTHER BEHAVIORS: (Check all that apply)

- Change in activity patterns or routines
- Change in eating behavior
- Change in mood (e.g. irritability, sadness, agitation)
- Change in mental status (e.g. increased confusion)
- Change in sleep pattern
- Change in interpersonal interactions (e.g. resistive to care, combative, withdrawn, socially disruptive)
- Other:

Checking "other" in any of the three assessment areas will open a free-text box. Enter observations not listed in the reminder in these text areas.

The direction of the change can be entered in the free-text box that appears after checking "other".

Assessment / reassessment intervals are per local policy, e.g., whenever full vital signs are taken.

ASSESSMENT FINDINGS:

- Assessment does not indicate there is a pain problem.
- Assessment indicates the patient may be experiencing pain
- Assessment identifies a non-pain problem that accounts for the observed behaviors and is being addressed.

Comment:

Behaviors noted may be consistent with depression or dementia, for example.

REASSESSMENT FINDINGS:

- Reassessment does not indicate there is a pain problem.
- Reassessment indicates the patient may be experiencing pain
- Reassessment identifies a non-pain problem that accounts for the observed behaviors and is being addressed.

Comment:

NOTE

Plan of Care should appear only if the assessment indicates possible pain.

PAIN PLAN OF CARE: (CHECK ALL THAT APPLY)

- Empirical trial of non-opioid analgesic with monitoring of treatment effects
- Empirical trial of opioid analgesic with monitoring of treatment effects
- Empirical trial of non-pharmacological interventions (such as soothing and supportive verbal communications, soothing and supportive touch, physical exercise and movement, and sensory stimulation, including music therapy and therapeutic massage, with monitoring of effects on behavior).

Comment:

- Reduce or increase environmental stimulation and monitor effects on behaviors
- Educate patient about pain care plan.
- Educate and involve family members in the patient's pain care plan
- Other: Comment:

Patient and/or family member should be informed of plan of care.

Choose at least one of the first three items, and any of the remaining four as appropriate.

REASSESSMENT DATE: Jun 27, 2007 ...

Reassessment date calendar.

## CR 5 Clinician Post-Operative Assessment / Reassessment

This reminder can be used in recovery rooms or on wards or units.

**Reminder Resolution: TEST PAIN SCREEN**

Complete a CLINICIAN POST-OPERATIVE PAIN ASSESSMENT/REASSESSMENT

WHAT TYPE(S) OF ANALGESIA IS THE PATIENT TAKING:

- PO
- IM
- IV
- PCA
- EPIDURAL
- NERVE BLOCK
- PHYSICAL-Examples include heat, cold, TENS, massage, etc.
- COGNITIVE-Examples include relaxation, hypnosis, etc.

IS THE PATIENT SEDATED? (Riker Sedation Agitation Scale (SAS))

- 0-NONE: ALERT AND EASY TO AROUSE
- 1-MILD: OCCASIONALLY DROWSY, EASY TO AROUSE
- 2-MODERATE: FREQUENTLY DROWSY, EASY TO AROUSE
- 3-SOMNOLENT: DIFFICULT TO AROUSE
- S-SLEEP: NORMAL SLEEP, WOULD BE EASY TO AROUSE

PAIN INTERFERENCE WITH COUGH AND DEEP BREATHING:  
(0="No Interference" 10="Extreme Interference")

Score: \*  0  1  2  3  4  5  6  7  8  9  10

PAIN INTERFERENCE WITH PATIENT MOVEMENTS:  
(0=No Interference 10=Extreme Interference)

SCORE: \*  0  1  2  3  4  5  6  7  8  9  10

IS THE PATIENT EXPERIENCING ITCHING?

- Yes
- No

IS THE PATIENT EXPERIENCING NAUSEA?

- Yes
- No

IS THE PATIENT EXPERIENCING ANY NEW WEAKNESS OR NUMBNESS?

- Yes
- No

More than one type of analgesia may be selected. Note that non-pharmacological analgesia are options.

Ricker Scale

Clinician judgment call on 0-10 scales

"Yes" responses to these three questions open free text boxes. Interventions can be entered in these text areas.

## CR 6 Clinician Monitor Opioid Therapy

The frequency of monitoring pain patients on opioid medication is determined by local policy. A sample opioid agreement is found in this manual's appendix.

**Reminder Resolution: TEST PAIN SCREEN**

Monitor OPIOID THERAPY

Available Urine Toxicology: NO RESULTS WITHIN LAST 730 DAYS

OPIOID AGREEMENT ON FILE:

Yes Comment: \_\_\_\_\_

No (consider signed agreement for chronic opioids)

OPIOID COMPLIANCE: (check all that apply)

OPIOID COMPLIANCE

No evidence of poor adherence

Abnormal urine drug screen

Urine drug screen positive for non-prescribed drug.  
Comment: \_\_\_\_\_

Urine drug screen negative for prescribed drugs.  
Comment: \_\_\_\_\_

Patient's urine toxicology suggests patient is not complying with opioid agreement.

Recurrent reports of lost, stolen or misplaced drugs

Multiple dose escalations without provider authorization

Obtaining prescription medications from other providers

Obtaining prescription medications from non-medical sources

Evidence supporting prescription forgery

Using a non prescribed route of opioid administration

OTHER: Comment: \_\_\_\_\_

If local policy requires an opioid agreement, date of agreement can be included in comment

If monitoring opioid compliance with urine tox screens, the most recently completed one (results and date) will appear here.

Comment boxes can be used to include details of abnormalities.

Checking any of the boxes suggestive of noncompliance may indicate the need for a change in the treatment plan, which can be documented in the comment box.

OPIOID EFFICACY:

Has pain intensity improved since last visit?

Yes

No (assess for worsening of condition)

Comment:

Per patient report with 0-10 score or behavioral factors.

Has QOL (i.e. activity, function, sleeping, etc) improved since last visit?

Yes

No

Comment:

ADVERSE REACTIONS TO THE PRESCRIBED OPIOID: (CHECK ALL THAT APPLY)

Constipation

Nausea and/or Vomiting

Itching

Sedation

Mental status changes (e.g. confusion)

Respiratory depression

Sexual decline

Other (specify):

Side effects may suggest the need for a change in the treatment plan, or additional patient education followed by making some shared decisions.

OPIOID TREATMENT PLAN OF CARE: (CHECK ALL THAT APPLY)

Continue same regimen

Increase dose to optimize therapy

Reduce dose to minimize side effects

Change to long acting opioid

Add adjuvants

Switch to another opioid

Taper off opioid

Start/adjust bowel protocol for constipation

Add anti-nauseant for nausea/vomiting

Other (specify):

Checked text will drop into CPRS note.

# CR 7 Nursing RN Assessment and Plan of Care

**NURSING**

- Complete a NURSING (RN) PAIN ASSESSMENT & PAIN CARE PLAN
  - QUALITY & LOCATION OF PAIN:
    - No change in quality or location of pain
    - Change in the quality or location of pain
  - COMPLIANT/NONCOMPLIANT WITH CURRENT PAIN PLAN:
    - Complied with the current pain plan or care.
    - NONcompliant with current pain plan of care
  - Comment:
  - IMPROVED FUNCTION (ABILITY TO DO DAILY ACTIVITIES, ETC.)
  - Comment:
  - Pain meds administered per order:
  - Comfort measures implemented:
  - Other comments:
- Complete a NURSING (RN) PAIN PLAN OF CARE:
  - COMFORT MEASURES:
    - Administer pain medication as ordered:
    - Cold:
    - Heat:
    - Massage:
    - Reposition:
  - COMMENTS RELATED TO Nursing Pain Plan of Care:

## CR 8 Nursing RN Pain Reassessment

Nursing reassessments need to be completed as frequently as local policy indicates, but must be completed at least as often as vital signs are taken and the previously reported pain score is  $\geq 4/10$ .

### Reminder Resolution: TEST PAIN SCREEN

Complete a NURSING (RN) PAIN REASSESSMENT & PAIN PLAN OF CARE

Continue current plan of care - pain scores within ACCEPTABLE range per patient. Current pain score: 0 (06/16/2004 09:04)

REASSESSMENT of Pain due to UNACCEPTABLE pain scores per patient. Current Pain score: 0 (06/16/2004 09:04)

QUALITY & LOCATION OF PAIN:

No change in quality or location of pain

Change in the quality or location of pain

COMPLIANT/NONCOMPLIANT WITH CURRENT PAIN PLAN:

Complied with the current pain plan or care.

NONcompliant with current pain plan of care

Comment: \_\_\_\_\_

IMPROVED FUNCTION (ABILITY TO DO DAILY ACTIVITIES, ETC.)

Comment: \_\_\_\_\_

Pain meds administered per order: \_\_\_\_\_

Comfort measures implemented: \_\_\_\_\_

Other comments: \_\_\_\_\_

Complete a NURSING (RN) PAIN PLAN OF CARE:

COMFORT MEASURES:

Administer pain medication as ordered: \_\_\_\_\_

Cold: \_\_\_\_\_

Heat: \_\_\_\_\_

Massage: \_\_\_\_\_

Reposition: \_\_\_\_\_

COMMENTS RELATED TO Nursing Pain Plan of Care:

\_\_\_\_\_

“Acceptable range, per patient” will be known from the initial assessment. Most recently entered pain score will appear here on the reminder. If plan is working, check “continue current plan of care.”

Document if there is a change in the quality or location of the pain, possibly indicating a new pain or increased disease.

Document and comment on compliance or lack of compliance with current plan and with functioning.

Document on pain meds administered and other measures implemented for pain.

Click to open to complete a nursing plan of care.

Free text box for any additional comments in care plan.

## CR 9 Nursing RN Cognitively Impaired Assessment Reassessment

Assessment and reassessment for patients who are cognitively impaired or have communication difficulties that do not allow them to use the Visual-Analog or the Wong-Baker (Faces) Scales can be completed utilizing the following reminder. Completion of this reminder does NOT result in a 0-10 pain score. To indicate in the CPRS record that a pain assessment or reassessment was completed, a score of "99" may be entered in the Vitals Package, depending on local policy. However, this reminder should also be completed to clearly chart patient behaviors possibly indicating pain, and the treatment of that pain.

**Reminder Resolution: TEST PAIN SCREEN**

Complete a NURSING (RN) COGNITIVELY IMPAIRED ASSESSMENT

BEHAVIORS THAT MAY INDICATE THE PRESENCE OF PAIN

AT REST: (CHECK ALL THAT APPLY)

- Patient verbalizes presence of pain
- Facial expressions of discomfort/distress
- Vocalizations (e.g. grunting, groaning, crying, sighing)
- Postural guarding (e.g. bracing, holding body part)
- Restlessness (e.g. repetitive movement, writhing)
- Other:

WITH MOVEMENT: (CHECK ALL THAT APPLY)

- Patient verbalizes presence of pain
- Facial expressions of discomfort/distress
- Vocalizations (e.g. grunting, groaning, crying, sighing)
- Restlessness (e.g. repetitive movement, writhing)
- Reluctance to move or to being moved
- Other:

OTHER BEHAVIORS: (Check all that apply)

- Change in activity patterns or routines
- Change in eating behavior
- Change in mood (e.g. irritability, sadness, agitation)
- Change in mental status (e.g. increased confusion)
- Change in sleep pattern
- Change in interpersonal interactions (e.g. resistive to care, combative, withdrawn, socially disruptive)
- Other:

After opening the reminder by clicking on "Complete a Nursing Cognitively Impaired..", click on "Behaviors That May Indicate The Presence Of Pain Behaviors" to see lists of possible pain behaviors

At Rest  
With Movement  
or Other Behaviors

Clicking on any of the three boxes above (Rest; Movement; Other) open the lists of behaviors shown.

Behaviors selected will appear in the CPRS progress note.

ASSESSMENT FINDINGS:

Assessment does not indicate there is a pain problem.

Assessment indicates the patient may be experiencing pain.

Assessment identifies a non-pain problem that accounts for the observed behaviors and is being addressed.

Comment:

REASSESSMENT FINDINGS:

Reassessment does not indicate there is a pain problem.

Reassessment indicates the patient may be experiencing pain.

Reassessment identifies a non-pain problem that accounts for the observed behaviors and is being addressed.

Comment:

The same reminder can be used for either an initial assessment or reassessment depending on which box is checked.

There is not currently any validated and reliable instrument used to measure pain in cognitively impaired patients. Some clinicians use such non-validated scales—many of which 'add up' to a 0-10 score.

A VHA consensus statement permits the use of such scales, but only as one part of a pain assessment or reassessment. Entering a 0-10 pain score derived from use of these instruments in the Vitals Package is NOT permitted.

## CR 10 Nursing LPN NA Observation Re-observation

For sites where LPNs and NAs are not permitted to assess, the assessment/ reassessment reminder for cognitively impaired patients has been modified. If local policies permit, LPNs and NAs can enter 0-10 pain scores and complete the following reminder template.

**Reminder Resolution: TEST PAIN SCREEN**

Complete a NURSING (LPN/NA) PAIN OBSERVATION

BEHAVIORS THAT MAY INDICATE THE PRESENCE OF PAIN

AT REST: (CHECK ALL THAT APPLY)

- Patient verbalizes presence of pain
- Facial expressions of discomfort
- Vocalizations (e.g. grunting, groaning, crying, sighing)
- Postural guarding (e.g. bracing, holding body part)
- Restlessness (e.g. repetitive movement, writhing)
- Other: Comment:

WITH MOVEMENT: (CHECK ALL THAT APPLY)

- Patient verbalizes presence of pain
- Facial expressions of discomfort/distress
- Vocalizations (e.g. grunting, groaning, crying, sighing)
- Restlessness (e.g. repetitive movement, writhing)
- Reluctance to move or to being moved
- Other: Comment:

OTHER BEHAVIORS: (Check all that apply)

- Change in activity patterns or routines
- Change in eating behavior
- Change in mood (e.g. irritability, sadness, agitation)
- Change in mental status (e.g. increased confusion)
- Change in sleep pattern
- Change in interpersonal interactions (e.g. resistive to care, combative, withdrawn, socially disruptive)
- Other: Comment:

**First**, click on “Complete a Nursing (LPN/NA)...” to open the reminder template.

**Second**, click on “Behaviors that may...” to see behaviors “At Rest”, “With Movement”, and “Other Behaviors”.

**Third**, by clicking on any one of those, this screen appears. Checking any of the boxes suggestive of possible pain inserts that description in the CPRS note.

This reminder can be used for either **initial observation** or for a follow-up

**re-observation**, depending on which box is clicked

**OBSERVATION FINDINGS:**

Observation does not indicate there is a pain problem.

Observation indicates the patient may be experiencing pain

Observation identifies a non-pain problem that accounts for the observed behaviors and is being addressed.

**REOBSERVATION FINDINGS:**

Reobservation does not indicate there is a pain problem.

Reobservation indicates the patient may be experiencing pain

Reobservation identifies a non-pain problem that accounts for the observed behaviors and is being addressed.

**COMMUNICATION OF FINDINGS**

Comment: \*

Whether an initial or a follow-up observation is performed, the "Communication of Findings" comment box opens. The LPN or NA is required to type in who (e.g., the RN or prescribing provider) is notified regarding the findings.

## CR 11 Record a Numeric Pain Score

**Reminder Resolution: TEST PAIN SCREEN**

PAIN MANAGEMENT MAIN MENU

Any clinician may enter a pain score. By entering it through this piece of the reminder (Record a Numeric Pain Score), the score is automatically entered in the Vitals Package. The "Action required" comment box also opens automatically for a free text response—critical if the patient's score is >3/10 (or whatever score your facility has set in its pain policy).

Remember: If assessing or reassessing pain in a cognitively impaired patient, only a score of "99" is entered in the Vitals Package. The assessment or reassessment reminder for cognitively impaired patients should be used to describe presumed pain and its treatment.

APPLICABLE TO ALL

Record a NUMERIC PAIN SCORE

Pain level: 1 - slightly uncomfortable

Action required: 0 - no pain

Complete PATIENT 1 - slightly uncomfortable

2

3

[LINK to Pain Clinic](#) 4

[LINK to VA Pain Man](#) 5

6

7

## CR 12 Pain Patient Education

This reminder was designed for any type of patient education, but with the education topics specifically suited to pain education. Joint Commission-required items (listed at the beginning of the reminder) must be completed in order to close the reminder. Checked items appear in the comment boxes and then in the CPRS note.

Complete PATIENT PAIN EDUCATION

The following items are required: Barriers to learning; Person taught; Teaching method; Teaching topic; Level of understanding; and Follow  
Checking the item opens a box and allows data to be entered.

\* Person(S) taught or teaching deferred

PATIENT  SPOUSE  SIGNIFICANT OTHER  RELATIVE

BARRIERS INHIBIT TEACHING NOW

Comment:

Assessment of special needs/barriers to learning. If barriers are identified, explain in comments box.

NO BARRIERS/NEEDS IDENTIFIED  LACK OF SOCIAL SUPPORT

PSYCHOLOGICAL/EMOTIONAL  CULTURAL/RELIGIOUS  COGNITIVE/MEMORY

DEXTERITY/MOBILITY  SEVERE ILLNESS  FINANCIAL  VISION IMPAIRMENT

SEVERE PAIN  SPEECH IMPAIRMENT  HEARING IMPAIRMENT  LANGUAGE

SOME ENGLISH  SPANISH ONLY

LITERACY LEVEL  DENIAL OF NEED FOR EDUCATION  LACK OF MOTIVATION

PATIENT'S TIME CONSTRAINT

Comment: \*

ACTIONS/TEACHING METHODS

VERBAL INSTRUCTIONS  WRITTEN INSTRUCTIONS  INTERPRETER USED  VIDEO

CLASS  DEMONSTRATION

SPANISH MATERIALS  LARGE PRINT MATERIALS

Comment:

If Severe Pain" is selected, educator may need to address education at a better time for

Click on "Person(s) taught," then the person or persons receiving the education.

Special needs/barriers must be noted.

Actions/Teaching Methods should be consistent with any barriers noted. If "Class" is selected, no assessment of learning is formally evaluated.

PAIN EDUCATION TOPICS:

- Use of 0-10 pain rating scale
- Pain medication
- Use of pain diary
- Weight management
- Exercise and stretching
- Invasive procedures
- Psychological pain management techniques
- Relationship of pain and activity
- Relationship of pain and mood
- Relationship of pain and interpersonal relations
- Recreation pain management techniques:
- Physical therapy:
- Occupational therapy:

LEVEL OF UNDERSTANDING WAS ASSESSED BY HAVING PATIENT:

REPEAT INFORMATION    RETURN DEMONSTRATION    ANSWER QUESTIONS  
 ASK PROVIDER QUESTIONS

Comment:

Level of Understanding: (None selected)

FOLLOW UP

PATIENT TO CALL WITH QUESTIONS    CONTINUE EDUCATION NEXT VISIT  
 REFERRED TO EDUCATION CLASS  
 REFERRED TO SUPPORT GROUP(S)  
 NO FOLLOW UP NEEDED   Comment: CONTINUE EDUCATION NEXT VISIT

Members of a multidisciplinary team have requested the pain Education Topics included, as staff from multiple clinical services should conduct pain education. Clicking on Recreation, Physical, and Occupational Therapy open comment boxes for topics to be entered in free text.

Four ways of assessing understanding are listed, with multiple checks permitted. A drop-down box allows the educator to note his/her perception of the patient's understanding.

The final Joint Commission education requirement is Follow –up. As with other Comment Boxes, the items checked appear on the screen and in the CPRS note.

Note: If writing “free text” in a comment box, be sure to do so after checking any item in that section of the reminder. Checking an item after writing free text will erase all free text.

## CR 13 Intranet Pain Links

Reminder Resolution: TEST PAIN SCREEN

PAIN MANAGEMENT MAIN MENU

Links to VHA/DoD websites are included for "just-in-time" training.

Individual facilities might also consider linking to other documents specific to each site. For example, linking to facility algorithms for treatment of different types of pain might be helpful to clinicians.

PLAN OF CARE

MENT

Complete a NURSING (LPN/NA) PAIN OBSERVATION/REOBSERVATION

APPLICABLE TO ALL

Record a NUMERIC PAIN SCORE

Complete PATIENT PAIN EDUCATION

[LINK to Pain Clinical Practice Guidelines](#)

[LINK to VA Pain Management Website](#)