

Acute postoperative pain management - assessment

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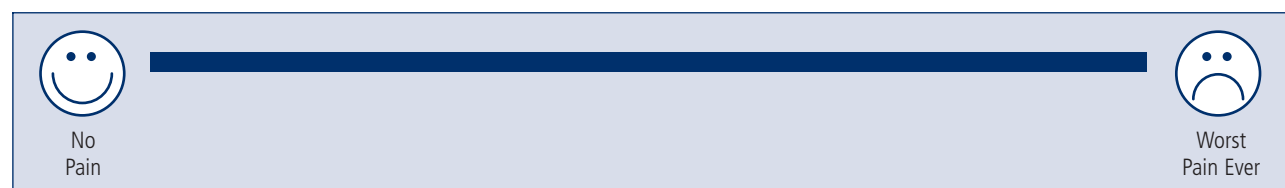
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Measure pain regularly using a validated pain assessment tool

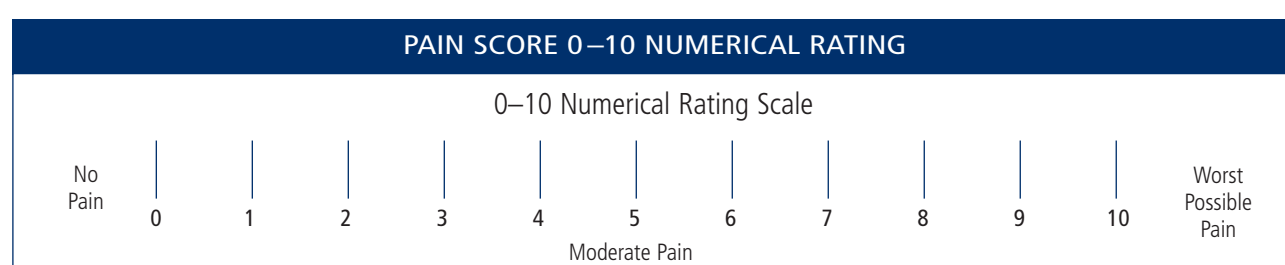
Regular and routine assessment of pain will result in improved pain management¹

- The patient's own assessment of pain is the most reliable and should be used when possible.¹
- Use a pain measurement tool appropriate to patient's mental status, age and language and when possible allow the patient to choose the pain assessment tool.
- Measure pain scores both at rest and on movement/function to assess the impact on functional activity.^{1,2,3}
- Re-assess pain regularly and before/after administering analgesia or other pain management strategies.
- Document pain assessment measurements and sedation scores as part of routine patient observations.

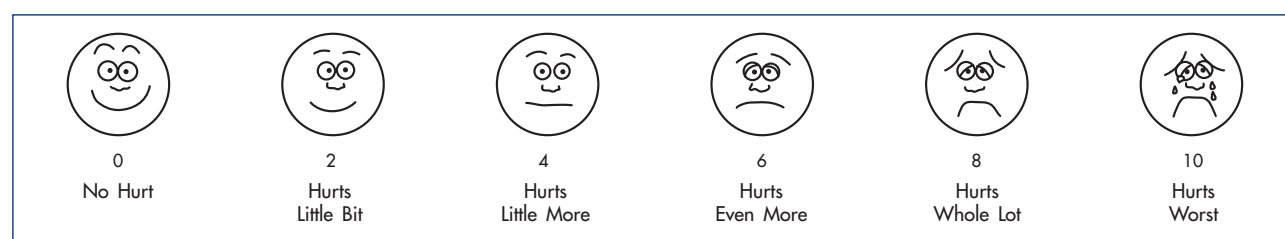
Assessment tools



Visual analogue scale (VAS) – Useful in a wide range of clinical environments, but may be limited in the cognitively or visually impaired and sedated patients.



Numerical rating scale (NRS) – Can be used verbally or visually and is useful in most settings, but has limitations in the elderly, cognitively impaired and patients with communication difficulties.



Faces rating scale (FRS) – Useful for children and patients with poor language skills. There are a number of different versions available; the Wong Baker Face Scale is a commonly used example.

Wong-Baker FACES Pain Rating Scale, from Wong DL et al.: Whaley and Wong's Essentials of Pediatric Nursing, 5th edition, St. Louis, 2001, Mosby, p. 1301. <http://www.mosbysdrugconsult.com/WOW/facesReproductions.html> (accessed 31 January 2007).

Face	0 Face muscles relaxed	1 Facial muscle tension, frown, grimace	2 Frequent to constant frown, clenched jaw	Face score:
Restlessness	0 Quiet, relaxed appearance, normal movement	1 Occasional restless movement, shifting position	2 Frequent restless movement may include extremities or head	Restlessness score:
Muscle tone*	0 Normal muscle tone	1 Increased tone, flexion of fingers and toes	2 Rigid tone	Muscle tone score:
Vocalisation**	0 No abnormal sounds	1 Occasional moans, cries, whimpers and grunts	2 Frequent or continuous moans, cries, whimpers or grunts	Vocalisation score:
Consolability	0 Content, relaxed	1 Reassured by touch, distractible	2 Difficult to comfort by touch or talk	Consolability score:
Behavioural pain assessment scale total (0–10)				/10

Behavioural rating scale³ – Objective assessment by observer (e.g. nurse) and therefore useful in patients who are unable to provide a self-report of pain such as those who are cognitively impaired, confused or who have language difficulties. This is scored 0-10 using clinical observations.

* Assess muscle tone in patients with spinal cord lesion or injury at a level above the lesion injury. Assess patients with hemiplegia on the unaffected side.
** This item cannot be measured in patients with artificial airways.

Sedation scoring		Suggested action
0	Awake, alert	Continue routine monitoring
1	Mild sedation	
1S	Asleep	
2	Moderate sedation, easy to rouse but unable to stay awake	Consider reducing analgesic dose, increase frequency of monitoring If respiratory rate < 8 breaths per minute, withhold opioid, administer naloxone* and notify medical officer
3	Difficult to rouse, unable to stay awake	Withhold opioid, administer naloxone* and notify medical officer

Sedation score – For use in patients prescribed opioids ± sedatives. Respiratory rate alone as an indicator of respiratory depression is of limited value and hypoxaemic episodes may occur in the absence of a reduced respiratory rate.¹ Sedation scores are a more reliable indicator – respiratory depression is almost always preceded by sedation.^{1,4} The sedation score measures the patient's level of wakefulness and their ability to respond appropriately to verbal command.

* Note that naloxone can cause uncontrolled pain/pulmonary oedema in the setting of opioid analgesia and should be administered IV in divided doses of not greater than 100 micrograms.

1. Australian and New Zealand College of Anaesthetists (ANZCA). Acute pain management: scientific evidence, 2nd edition. ANZCA, 2005. <http://www.anzca.edu.au/publications/acutepain.htm> (accessed April 2007).
 2. Clinical Practice Guideline for the Management of Postoperative Pain, Veterans Health Administration and Department of Defence, United States of America http://www.oqpmc.org/pain/pain_base.htm (accessed April 2007).
 3. Acute Pain Management Measurement Toolkit, Victorian Quality Council, 2007 <http://www.health.vic.gov.au/qualitycouncil/activities/acute.htm> (accessed April 2007).
 4. Macintyre PE, Schug SA. Acute Pain Management – A Practical Guide, 3rd edition, 2007 (in press).

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