Skeletal – Pain Assessment

Strength of Evidence Level: 1

PURPOSE:
To assess pain in skeletal system before, during or after activities.

CONSIDERATIONS:
1. Patients with cognitive deficits and infants/young children may be unable to participate in standard pain assessment, so appropriate pain assessment tools should be used with these patient populations.
2. No single pain assessment tool is recommended. However, a standardized tool should be selected and used following administration directions.
3. Pain should be considered the fifth vital sign, and best practice standards reflect that pain is assessed on each home visit.

EQUIPMENT:
If using standardized assessment tool using visual component, such as FACES scale or Visual Analog Scale, have visual reference material ready.

PROCEDURE:
1. Explain assessment to patient.
2. Provide privacy, if appropriate.
3. Be prepared to ask about pain in patient’s primary language.
4. Provide adequate time for patient to consider pain questions and respond accordingly.
5. Administer standardized pain assessment based on clinician’s assessment of most appropriate pain assessment tool to use.
6. Key factors regarding pain to assess:
   a. Location – exact site if possible to locate; if multiple sites, are they related?
   b. Intensity – maximal and minimal pain levels
   c. Duration – length of time at maximal pain, ramp-up and ramp-down time frames
   d. Frequency – how often pain occurs
   e. Flare-ups – what aggravates the pain?
   f. Cool-downs – what helps decrease the pain?
7. Clinician should observe any key factor information in Step 6 above with quality of movement and ability to participate in activities for self-care or pleasure.

AFTER CARE:
1. Document in patient’s record:
   a. Pain assessment findings.
   b. Standardized pain tool used.
   c. Patient’s response to assessment.
   d. Any recommended follow-up actions based on findings from pain assessment.

REFERENCES:
