PAIN ASSESSMENT ACROSS THE LIFESPAN

MSHA 2023

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CENTRAL MICHIGAN UNIVERSITY
MT. PLEASANT

therapists
training therapists

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MiOTA
Michigan Occupational Therapy Association, Inc.

WESTERN MICHIGAN BRONCOS

Celebrating 125 Years
BAY PATH
1897 – UNIVERSITY – 2022
REimagine Possibility

LEARNING OBJECTIVES

At the conclusion of this program attendees will:

Identify at least three manifestations of pain that can impact life satisfaction and successful engagement in valued roles.

Identify at least three pain assessments appropriate to be used by a health professional.

Identify at least three treatment methods that can be used to prepare a patient to be able to engage in purposeful and/or occupational tasks.

LET'S UNDERSTAND THE STATISTICS

Half of all hospitalized patients pain in their last days of their lives (Tristani and Lafrenz, 2017).

Estimated that 20% of adults report that pain or physical discomfort disrupts their sleep a few nights or more per week (Tristani and Lafrenz, 2017).

Medication overdose deaths has quadrupled.

Adverse drug reactions and drug effects leads to increased admissions to emergency room and hospital.

According to DeNoon (2011), opioid prescription overdose is the leading cause of death related to drug overdose, killing more individuals than overdoses in heroin and cocaine combined.

COST OF PAIN

Annual cost of pain as of 2010 in the U.S. ranges from $560 to $635 billion (Gaskin and Richards, 2012).

Medical costs

Disability days

Lost wages

Reduced productivity

PREVALENCE OF CHRONIC PAIN

Cancer (11.9 million)

Diabetes (25.8 million)

Chronic Pain (100 million)

Stroke (7 million)

Coronary Heart Disease (16.3 million)

WHAT IS THE U.S. DOING?

Institute of Medicine (2011) created a report titled *R*elieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.

US Department of Health and Human Services then developed a follow up plan titled the National Pain Strategy (NPS). NPS recommends to address barriers to all modalities for treating pain and reducing the stigma around pain.

R 338.629 Acceptable continuous professional development activities; requirements, limitations.

Rule 29. (1) The 20 CPD credits required under R 338.627(2) for the renewal of a license must satisfy the following requirements as applicable:

(a) No more than 12 CPD credits may be earned for approved CPD programs or activities during one 24-hour period.

(b) A licensee cannot earn CPD credit for a CPD program or activity that is substantially identical to a program or activity the licensee has already earned credit for during that renewal period.

(c) Under section 16204(2) of the code, MCL 333.16204, a licensee shall earn at least 1 CPD credit in the area of pain and symptom management by completing a CPD program or activity. Credits in pain and symptom management may include, but are not limited to, courses or activities relevant to the practice of speech-language pathology and relating to the public health burden of pain; ethics and health policy relating to pain; pain definitions; basic sciences including pharmacology, psychology, and sociology; clinical sciences relating to pain; clinician-patient communications as relating to pain; management of pain including evaluation and treatment; ensuring quality pain care; and programs and resources relevant to pain.

MANDATING EDUCATION

CHILDREN & MULTI-MODAL TREATMENTS

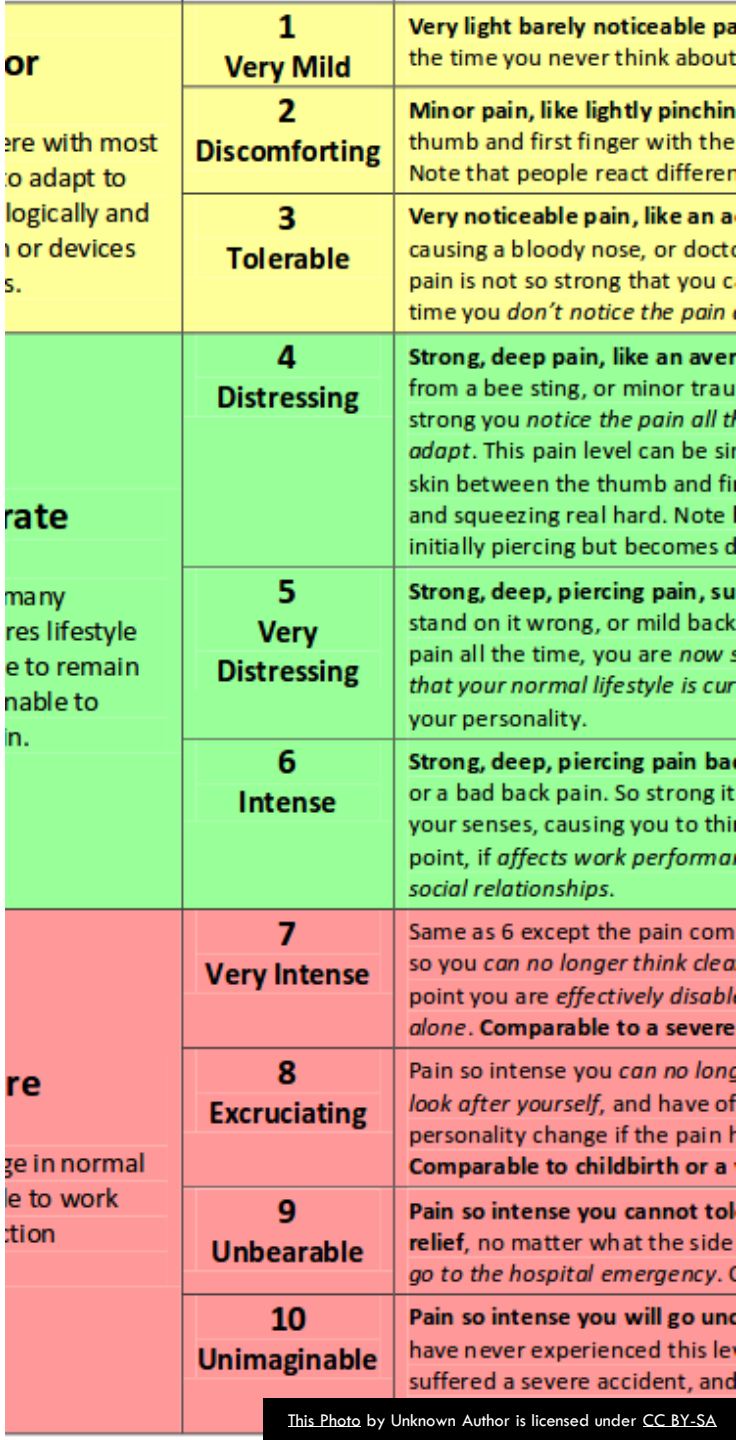
Medication & non-pharmacological modalities such as biofeedback, massage, aromatherapy, bubble blowing

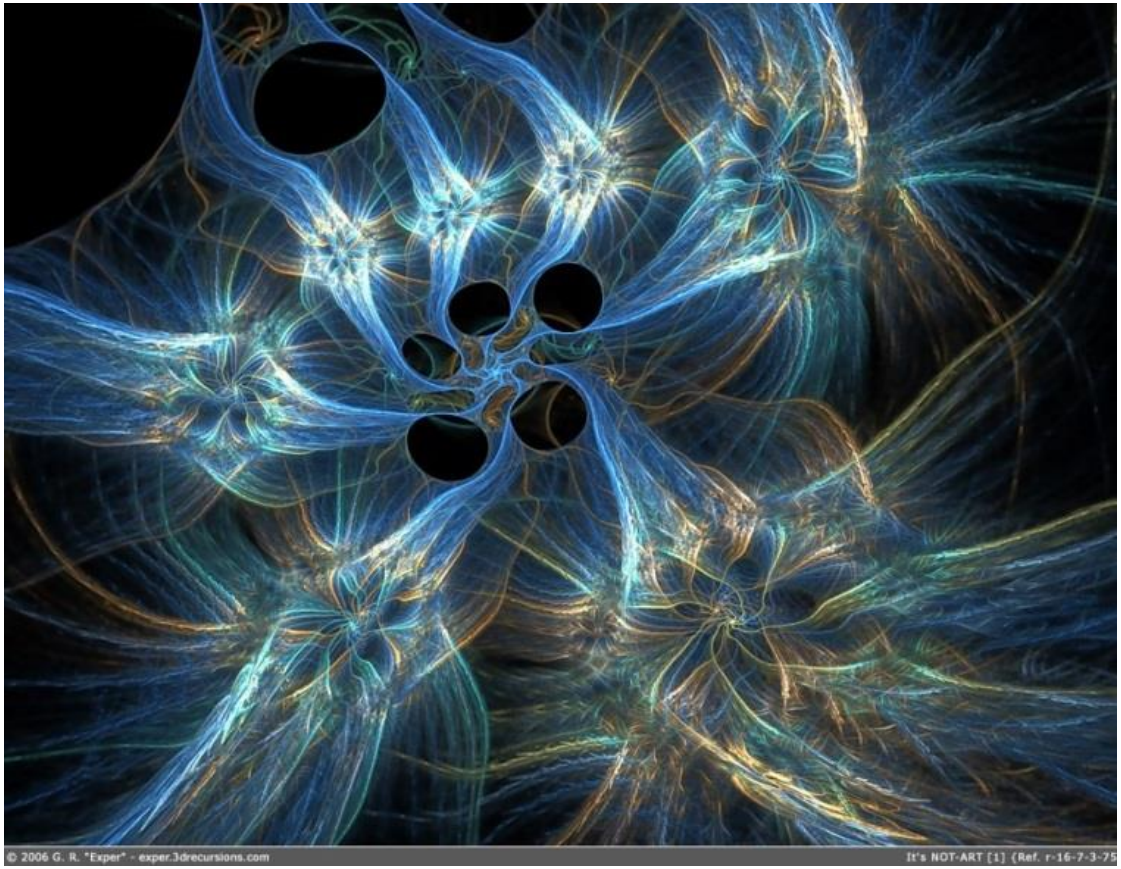
Cognitive behavioral techniques

DEVELOPMENTAL APPROACH TO PAIN ASSESSMENT

Toddlers – quiet, inactive or become overactive; parents report not acting normal; can become acted out in aggressive outbursts

School-age children – more accurate in communicating pain; by 8 years can reliably describe location of pain; Symptom scales and self-report tools appropriate; older than 8 can use the concept of Numerical Rating Sale; also Pain diaries helpful at this age





WHAT IS PAIN?

Complex sensory, emotional and behavioral experience. It is an actual or perceived threat to tissue damage.

Subjective

- It is -- multi-dimensional

DEFINITION OF PAIN

What is pain?

Components of pain

What influences pain?

How is pain communicated?

COMPONENTS OF PAIN

- Emotional: fear, anxiety, depression, anger
- Cognitive: values, meaning, culture, expectation
- Behavioral: coping style, problem solving, support seeking or isolation, avoid, escape, pray/hope
- Physical: Actual physical sensory experience

PAIN CONSEQUENCES

- Multiple medication use
- Falls
- Dysfunction in occupational performance
- Cognitive Impairment
  - Disorientation, ability/inability to perform executive functioning abilities
- Social withdrawal/depression/suicide
- Sleep/appetite disturbances

COMMON MISCONCEPTIONS

Pain is a normal part of aging.

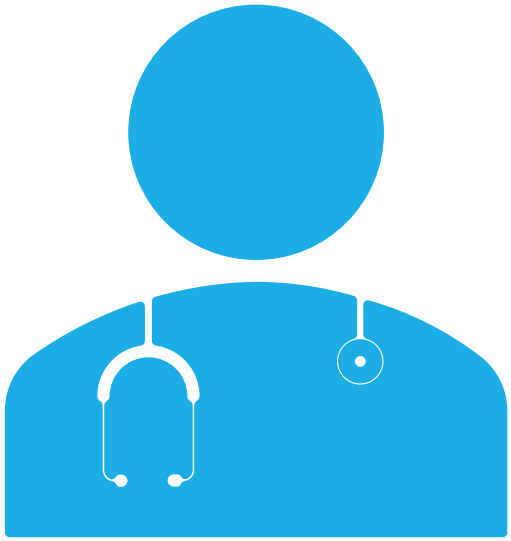
All pain medications are addictive.

If you don't complain you don't have pain.

No pain no gain.

I just must live with it.

Treatment will be painful.



PHYSIOLOGY OF PAIN

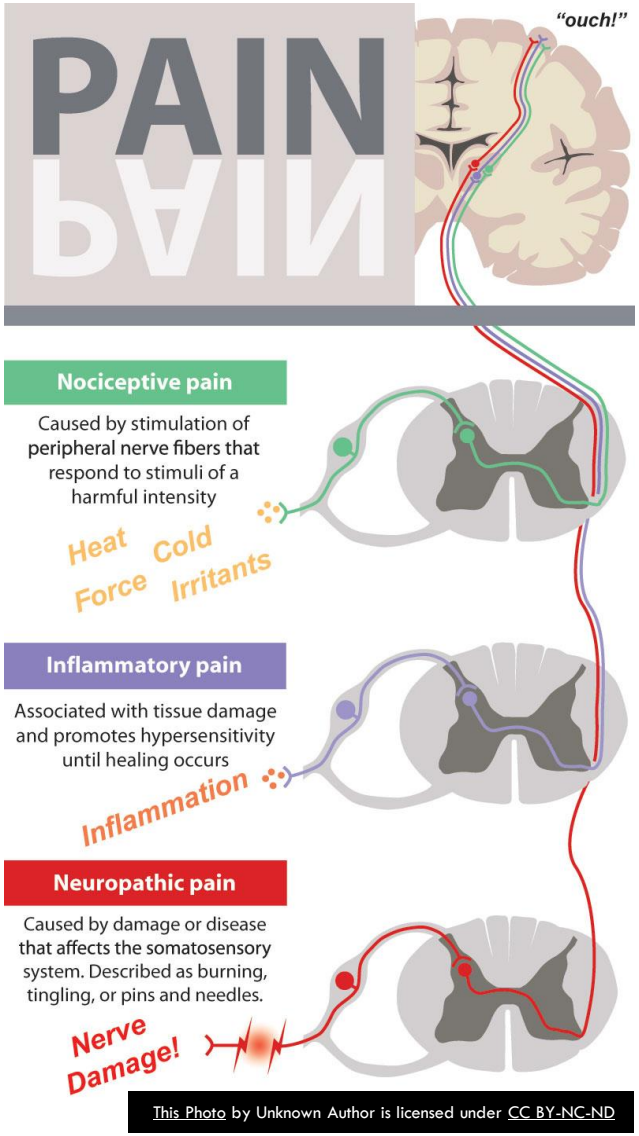
Peripheral Nerves

- Nociceptors -receptors that detect actual or potential tissue damage– mechanism for "feeling" pain
- Dense in critical areas – tongue, fingertips, genitals, skin, muscles, tendons

Neurotransmitters

- Chemicals that transmit messages from one nerve to another

Ascending and Descending Pathways



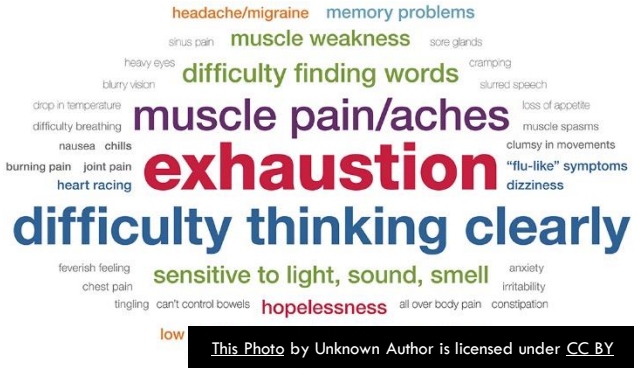
FACTORS IMPACTING PAIN

Gender – research shows women have higher sensitivity to pain than men, sex-linked genetic traits or hormonal factors

Age – with age the brain circuitry degenerates, therefore older adults have lower pain thresholds

Memory – our experience with pain, influences neural responses

Fatigue – when body is stressed due to lack of sleep one can experience more pain



PAINFUL CLINICAL CONDITIONS

Cancer

Degenerative diseases: OA, Osteoporosis

Fibromyalgia

Inflammatory diseases: RA

Peripheral Neuropathy

Neurogenic Pain

Central Pain Syndrome: TBI,CVA, MS

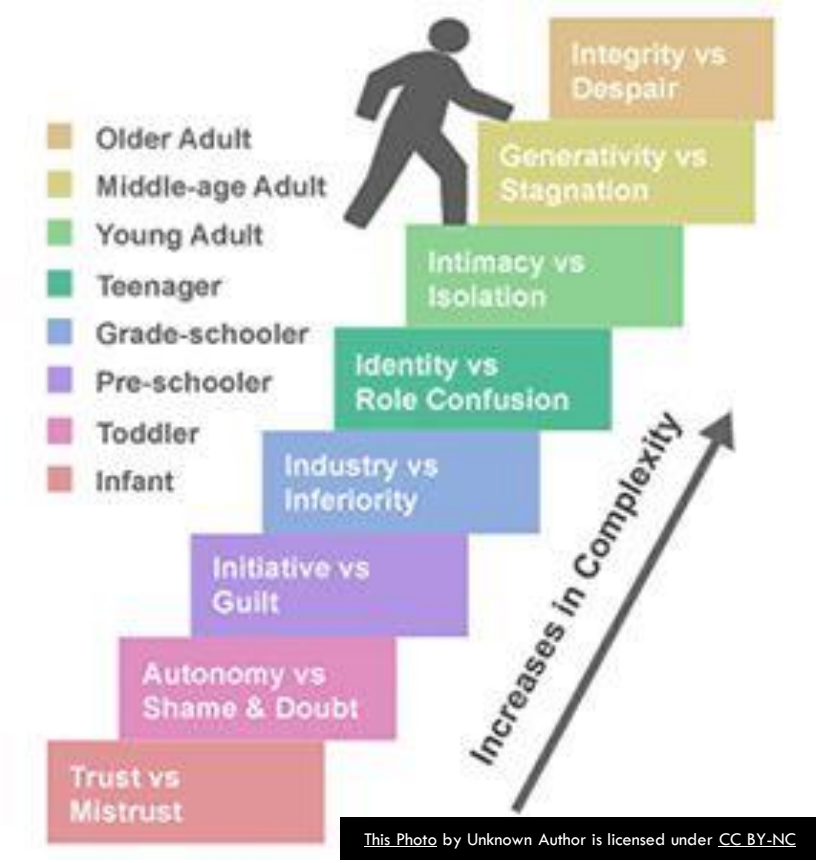
Trigeminal Neuralgia

Post surgical pain

Back pain (acute and chronic)

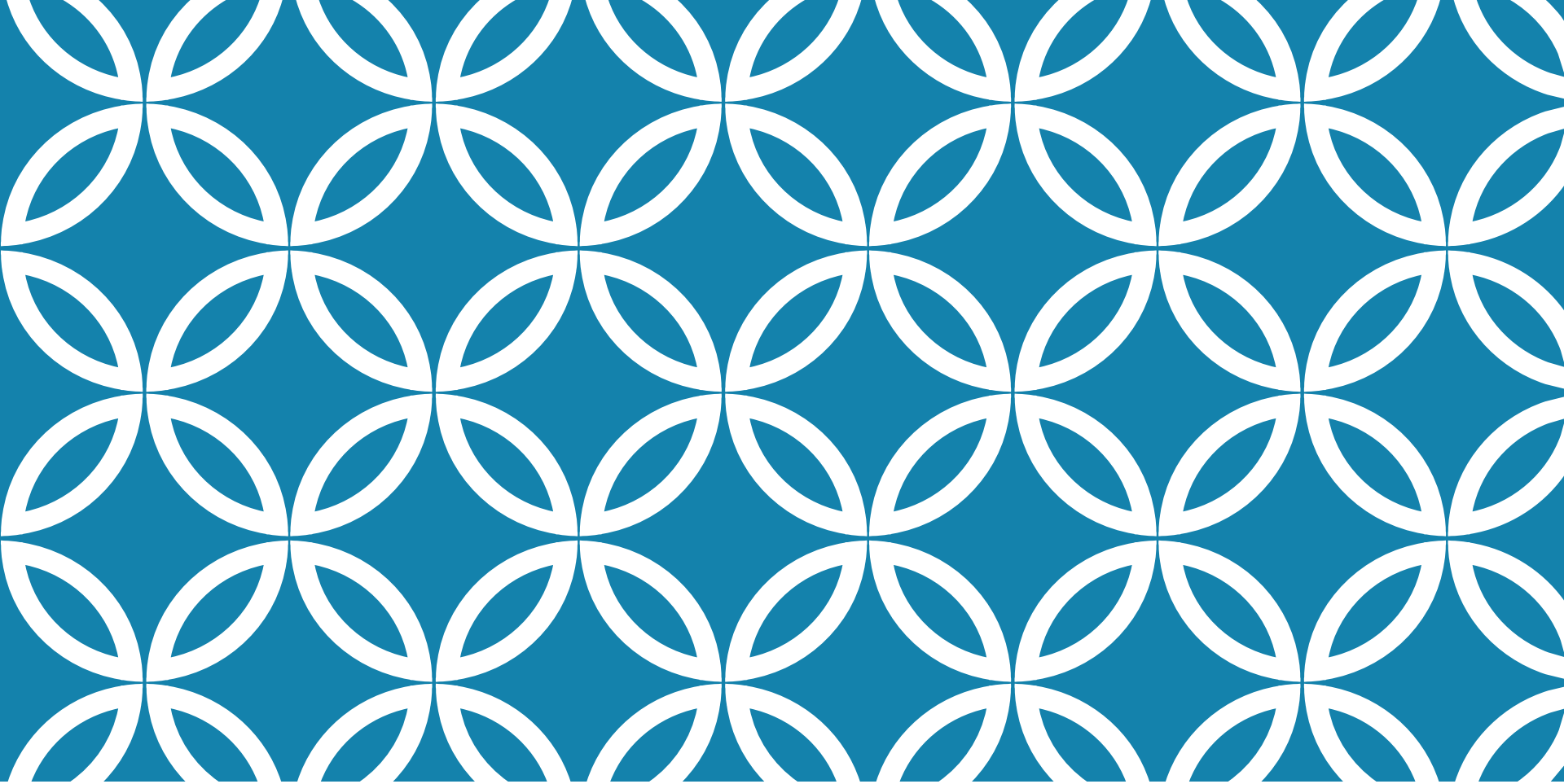
Healing fracture

ACROSS THE LIFESPAN



PEDIATRICS AND GERIATRICS

While not having a lot of great similarities physiologically, share the common thread of under-medication for pain.



TYPES OF PAIN

Acute
Chronic

ACUTE PAIN

Sudden onset

Usually brief

Pain subsides as healing occurs

IF left untreated can lead to chronic pain

Classified as lasting 1-4 days

- Vascular changes
- Exudation of cells and chemicals
- Clot formation
- Phagocytosis – absorbing of necrotic cells
- Clinical signs: inflammation (swelling, heat, redness) Pain before tissue resistance (guarding) Loss of function – mobility, strength, sensation

CHRONIC PAIN

Persistent

Weeks, months, and years – anything greater than 4 weeks of normal healing time of diagnosis is characterized as chronic.

Intensity can range from mild to severe

Often results in multiple medication use

Can be associated with psychosocial and physical conditions

CHRONIC DISEASE MANAGEMENT REQUIRES INTERPROFESSIONAL COLLABORATION

Integrative Pain Management

Wide range of interprofessional techniques are important to introduce to persons with pain as they can become resistant to conventional medical treatment.

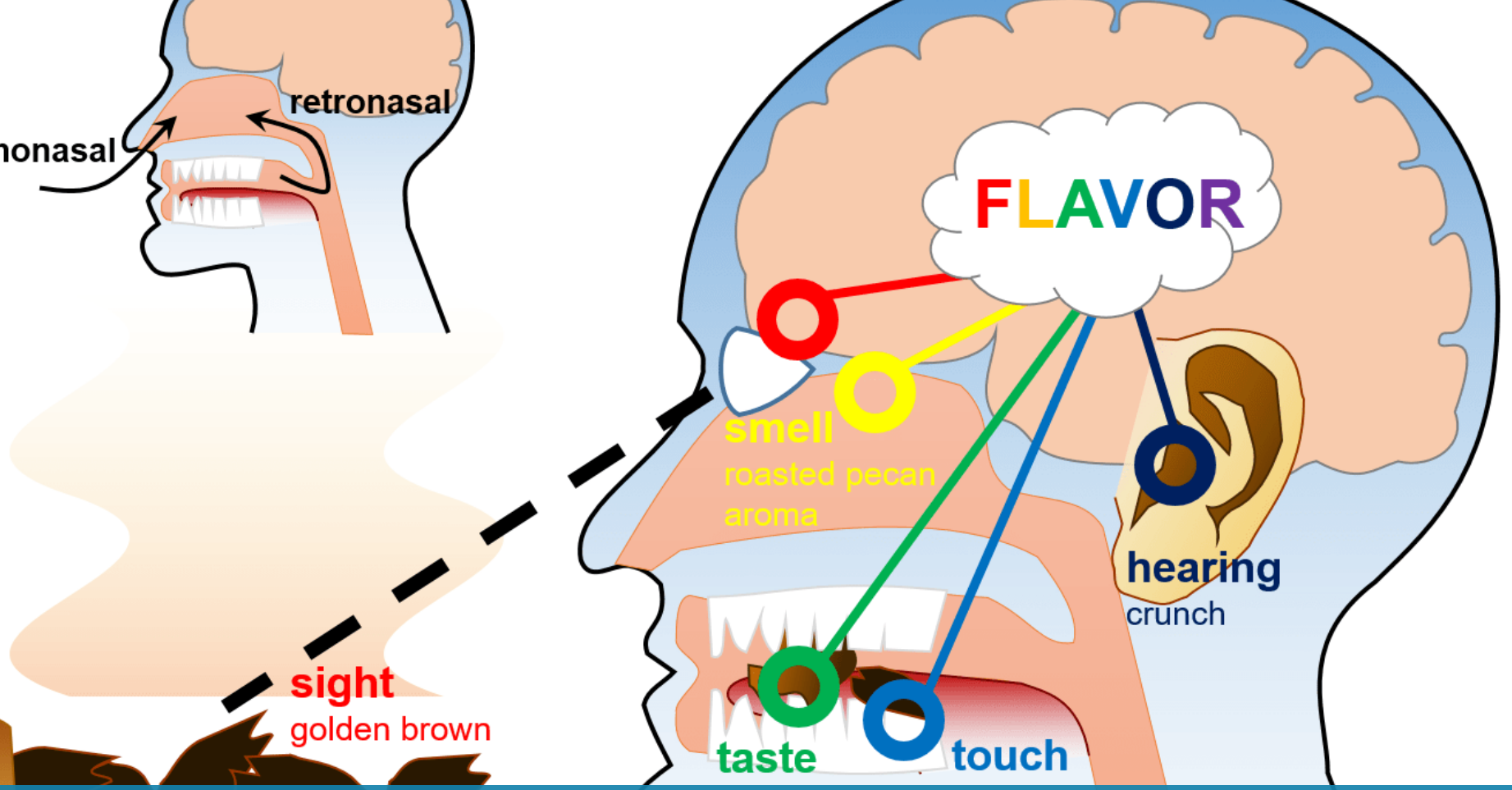
Patient-centered care addressing not just the physical aspects of pain but also the emotional, mental, spiritual, social, and environmental influences.

SLP looks at non-verbal communication and non-verbal signs and symptoms indicative of pain.

Often the first health professional to identify/report is SLP.

Teach the use of alternative communication to report pain.

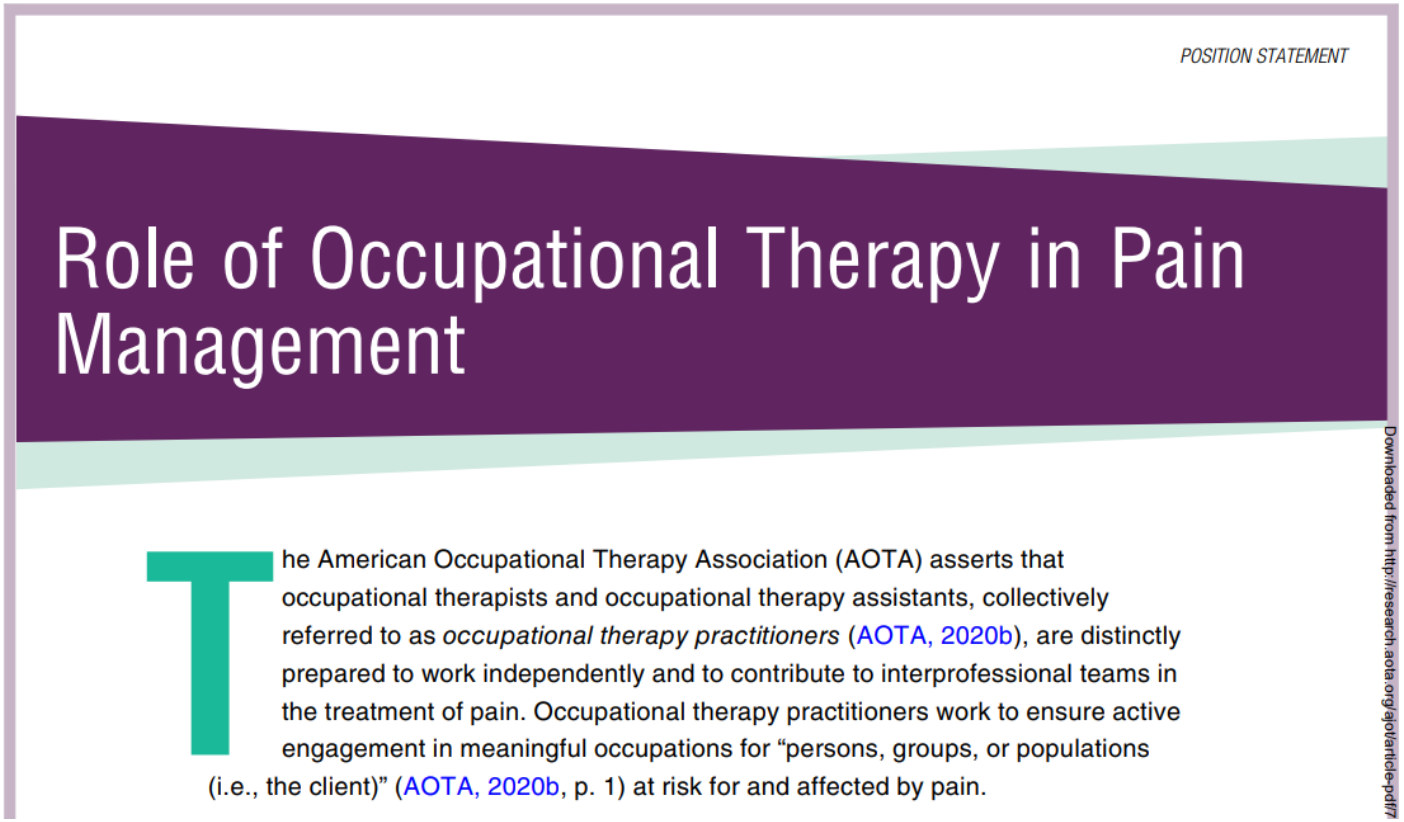
ROLE OF SPEECH LANGUAGE PATHOLOGIST – PAIN ASSESSMENT AND MANAGEMENT



SLP

Cognitive and sensory Stimulation interventions to decrease pain.

RESOURCE FROM AOTA



POSITION STATEMENT

Role of Occupational Therapy in Pain Management

The American Occupational Therapy Association (AOTA) asserts that occupational therapists and occupational therapy assistants, collectively referred to as *occupational therapy practitioners* (AOTA, 2020b), are distinctly prepared to work independently and to contribute to interprofessional teams in the treatment of pain. Occupational therapy practitioners work to ensure active engagement in meaningful occupations for "persons, groups, or populations (i.e., the client)" (AOTA, 2020b, p. 1) at risk for and affected by pain.

RE-TRAIN YOUR BRAIN

Pain is 100% in the brain

Learn to calm nervous system

Retrain the brain

EVALUATION

A DETAILED EVALUATION IS CRITICAL TO IDENTIFYING THE UNDERLYING CAUSE OF THE PAIN AND ESTABLISHING THE PLAN OF CARE

IMPLIES DATA COLLECTION, INTERPRETATION AND SYNTHESIS OF THE INFORMATION TO CREATE A TREATMENT PLAN

EVALUATION

- Type of Pain: bone, vascular, nerve, muscle
- Joint movement
- Circulatory problems
- Deformity – scoliosis/kyphosis
- Body symmetrics

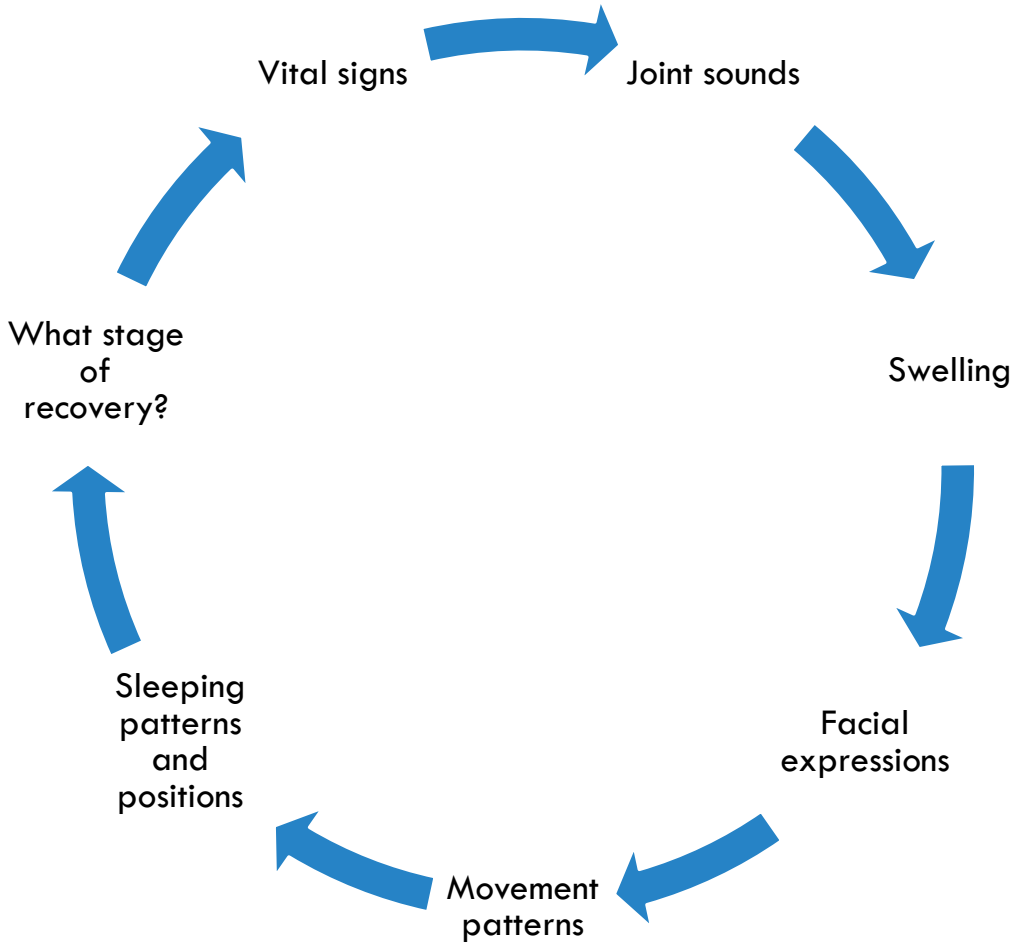
TYPE OF PAIN:

Nerve
- Nerve: manifests in sharp, burning, tingling – follows nerve distribution patterns

Bone
- Bone: deep boring and localized

Diffuse
- Vascular: diffuse, aching, poorly localized, referred to other parts of body (blood clot)

Muscle
- Muscle pain: dull, aching, aggravated by injury



EVALUATION CONTINUED:

Pain associated w/ rest or activity, postures and time of day

- Pain w/ activity, decreased w/ rest
- Mechanical obstruction with movement – adhesion?
- Morning pain that decreases w/ activity
- Congestion of the joint, edema

EVALUATION: CONTINUED

INTERVIEW

ASK PATIENT IF THEY HAVE PAIN

NOTE IF THEY ARE RELUCTANT TO DISCUSS PAIN

AMERICAN PAIN FOUNDATION TARGET ACRONYM

Original Article

The American Pain Foundation *TARGET Chronic Pain* Initiative

Better Patient/Clinician Communication to Improve Pain Management

Michelle Rhiner (Advisory Board Member) (Manager and Patient Coordinator, Supportive Care, Pain and Palliative Medicine) (Advisory Board Member) (Manager and Patient Coordinator, Supportive Care, Pain and Palliative Medicine)

TARGET

T = Talk to your patients about pain

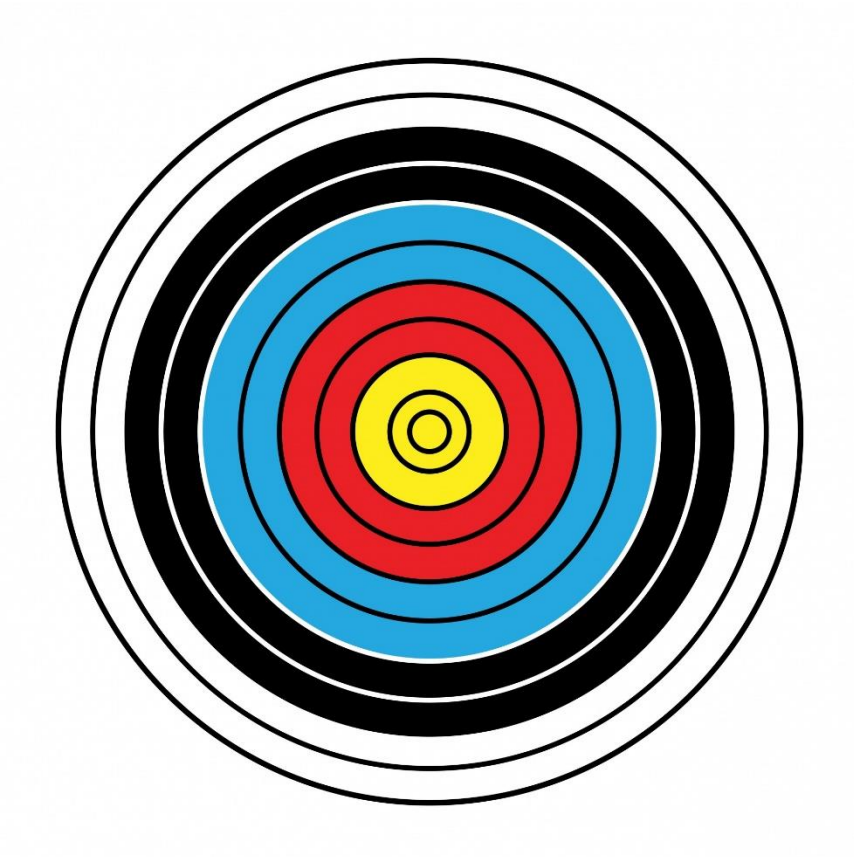
A = Ask about current treatments

R = Rate pain intensity and get details

G = Get details

E = Evaluation limitations

T = Treat side effects



QUANTIFY/QUALIFY

Quantify

- Establish baseline for comparison

Qualify

- Help localize pain producing structure(s)
- Intermittent or constant
- Central or distal
- Bilateral, 1 joint or multiple joints

ASSESSMENT TOOLS

- Wong Baker FACES Pain Scale – Revised
- Numerical Rating Scale
- Verbal Descriptor Scale
- FLACC
- Discomfort Scale – Dementia Alzheimer Type
- PAINAD
- Comfort Scale for Pain Assessment

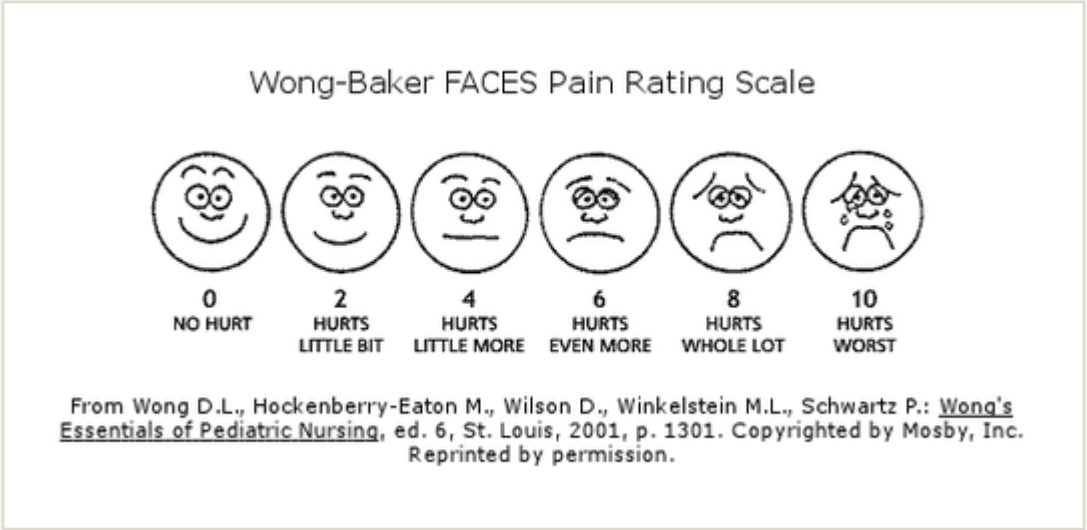
PAIN IS THE FIFTH VITAL SIGN

Impacts other vital signs.

A person with chronic pain can experience increased blood pressure, temperature, and pulse.

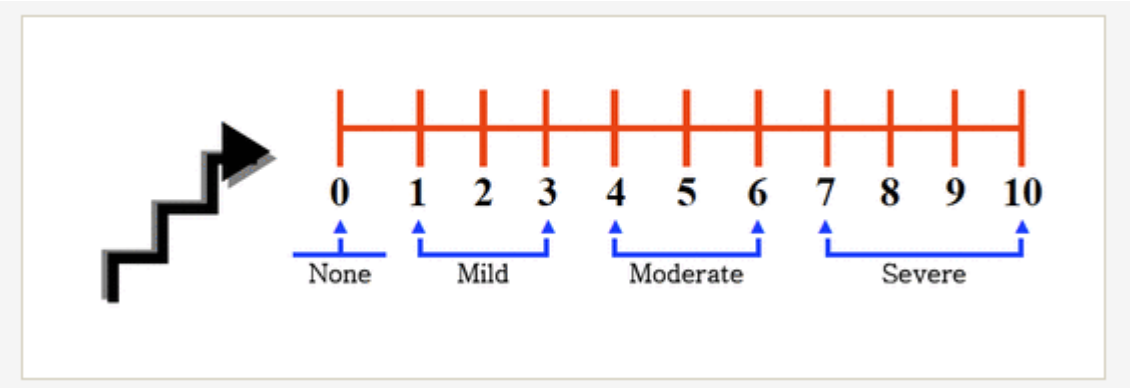
Vital Signs	
1st	Body Temperature
2nd	Pulse
3rd	Respiratory Rate
4th	Blood Pressure
5th	

WONG BAKER FACES



From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

NUMERICAL RATING SCALE



VERBAL DESCRIPTOR SCALE

Instructions: Please place a check mark next to the phrase that best describes the current level of your pain.

_____No Pain

_____Mild Pain

_____Moderate Pain

_____Severe Pain

_____Very Severe, Horrible Pain

PATIENTS WITH COMMUNICATION ISSUES

Look for signs of distress

Exit seeking

Agitation/crying

Aggressive behavior

Withdrawl

Catastrophic reactions

Sleep changes

Appetite and/or weight loss

Changes in bowel and bladder habits

COMFORT SCALE

NATIONAL INSTITUTES OF HEALTH
WARREN GRANT MAGNUSON CLINICAL CENTER

PAIN INTENSITY INSTRUMENTS
JULY 2003

COMFORT Scale (page 1 of 2)

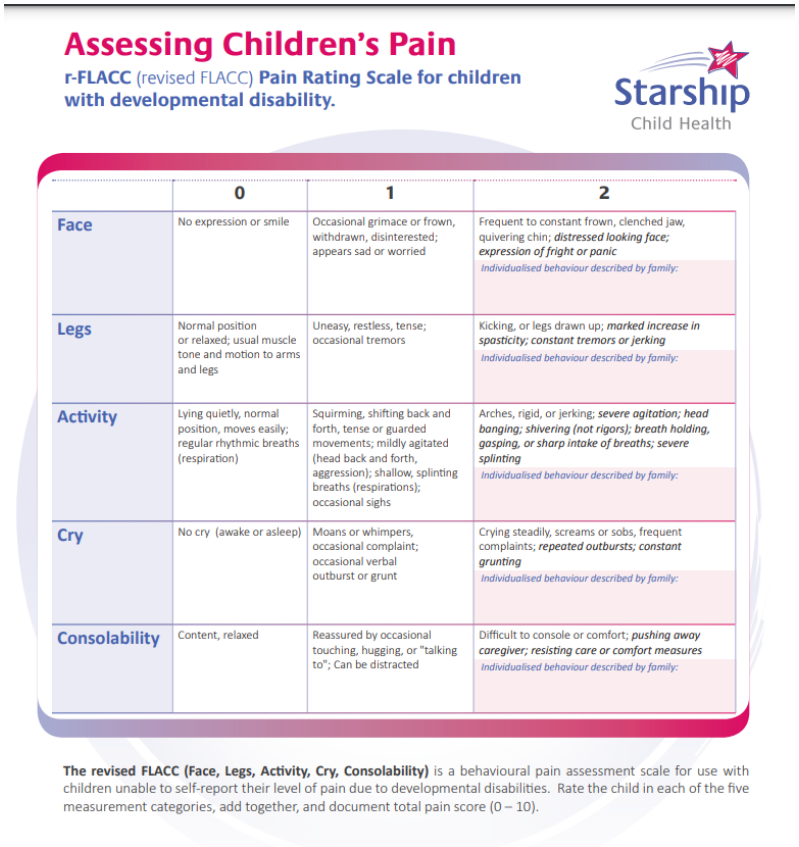
	DATE/TIME						
ALERTNESS	1 - Deeply asleep 2 - Lightly asleep 3 - Drowsy 4 - Fully awake and alert 5 - Hyper alert						
CALMNESS	1 - Calm 2 - Slightly anxious 3 - Anxious 4 - Very anxious 5 - Panicky						
RESPIRATORY DISTRESS	1 - No coughing and no spontaneous respiration 2 - Spontaneous respiration with little or no response to ventilation 3 - Occasional cough or resistance to ventilation 4 - Actively breathes against ventilator or coughs regularly 5 - Fights ventilator; coughing or choking						
CRYING	1 - Quiet breathing, no crying 2 - Sobbing or gasping 3 - Moaning 4 - Crying 5 - Screaming						
PHYSICAL MOVEMENT	1 - No movement 2 - Occasional, slight movement 3 - Frequent, slight movements 4 - Vigorous movement 5 - Vigorous movements including torso and head						
MUSCLE TONE	1 - Muscles totally relaxed; no muscle tone 2 - Reduced muscle tone 3 - Normal muscle tone 4 - Increased muscle tone and flexion of fingers and toes 5 - Extreme muscle rigidity and flexion of fingers and toes						
FACIAL TENSION	1 - Facial muscles totally relaxed 2 - Facial muscle tone normal; no facial muscle tension evident 3 - Tension evident in some facial muscles 4 - Tension evident throughout facial muscles 5 - Facial muscles contorted and grimacing						
BLOOD PRESSURE (MAP) BASELINE	1 - Blood pressure below baseline 2 - Blood pressure consistently at baseline 3 - Infrequent elevations of 15% or more above baseline (1-3 during 2 minutes observation) 4 - Frequent elevations of 15% or more above baseline (> 3 during 2 minutes observation) 5 - Sustained elevations of 15% or more						
HEART RATE BASELINE	1 - Heart rate below baseline 2 - Heart rate consistently at baseline 3 - Infrequent elevations of 15% or more above baseline (1-3 during 2 minutes observation) 4 - Frequent elevations of 15% or more above baseline (> 3 during 2 minutes observation) 5 - Sustained elevations of 15% or more						
	TOTAL SCORE						

Instruotions for use of the Comfort Soale on page 2 of 2

FLACC

DATE/TIME						
Face 0 - No particular expression or smile 1 - Occasional grimace or frown, withdrawn, disinterested 2 - Frequent to constant quivering chin, clenched jaw						
Legs 0 – Normal position or relaxed 1 – Uneasy, restless, tense 2 – Kicking, or legs drawn up						
Activity **0** – Lying quietly, normal position, moves easily **1** – Squirming, shifting back and forth, tense **2** – Arched, rigid or jerking						
Cry **0** – No cry (awake or asleep) **1** – Moans or whimpers; occasional complaint **2** - Crying steadily, screams or sobs, frequent complaints						
Consolability **0** – Content, relaxed **1** – Reassured by occasional touching, hugging or being talked to, distractible **2** – Difficult to console or comfort						
TOTAL SCORE						

R-FLACC



Assessing Children's Pain

r-FLACC (revised FLACC) **Pain Rating Scale for children with developmental disability.**

Starship Child Health

	0	1	2
Face	No expression or smile	Occasional grimace or frown, withdrawn, disinterested; appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin; ***distressed looking face; expression of fright or panic*** *Individualised behaviour described by family:*
Legs	Normal position or relaxed; usual muscle tone and motion to arms and legs	Uneasy, restless, tense; occasional tremors	Kicking, or legs drawn up; ***marked increase in spasticity; constant tremors or jerking*** *Individualised behaviour described by family:*
Activity	Lying quietly, normal position, moves easily; regular rhythmic breaths (respiration)	Squirming, shifting back and forth, tense or guarded movements; mildly agitated (head back and forth, aggression); shallow, splinting breaths (respirations); occasional sighs	Arches, rigid, or jerking; ***severe agitation; head banging; shivering (not rigors); breath holding, gasping, or sharp intake of breaths; severe splinting*** *Individualised behaviour described by family:*
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; occasional verbal outburst or grunt	Crying steadily, screams or sobs, frequent complaints; ***repeated outbursts; constant grunting*** *Individualised behaviour described by family:*
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or "talking to"; Can be distracted	Difficult to console or comfort; ***pushing away caregiver; resisting care or comfort measures*** *Individualised behaviour described by family:*

The revised FLACC (Face, Legs, Activity, Cry, Consolability) is a behavioural pain assessment scale for use with children unable to self-report their level of pain due to developmental disabilities. Rate the child in each of the five measurement categories, add together, and document total pain score (0 – 10).

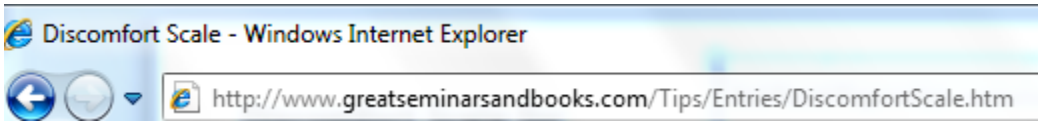
DISCOMFORT SCALE FOR DEMENTIA OF THE ALZHEIMER'S TYPE (DS-DAT)

- Requires no verbal resp9onse
- Observation assessment tool
- Assist therapists in defining progress and improvement
- Tool reviews observations as well as frequ of behavior in a 5 minute period, Duratio behavior and description of intensity (high low0

- Observations include:
  - Noisy Breathing
  - Negative Vocalizations
  - Lack of Content of Facial Expressions
  - Sad Facial Expression
  - Frightened Facial Expression
  - Frown
  - Lack of Relaxed Body Language
  - Tense Body Language

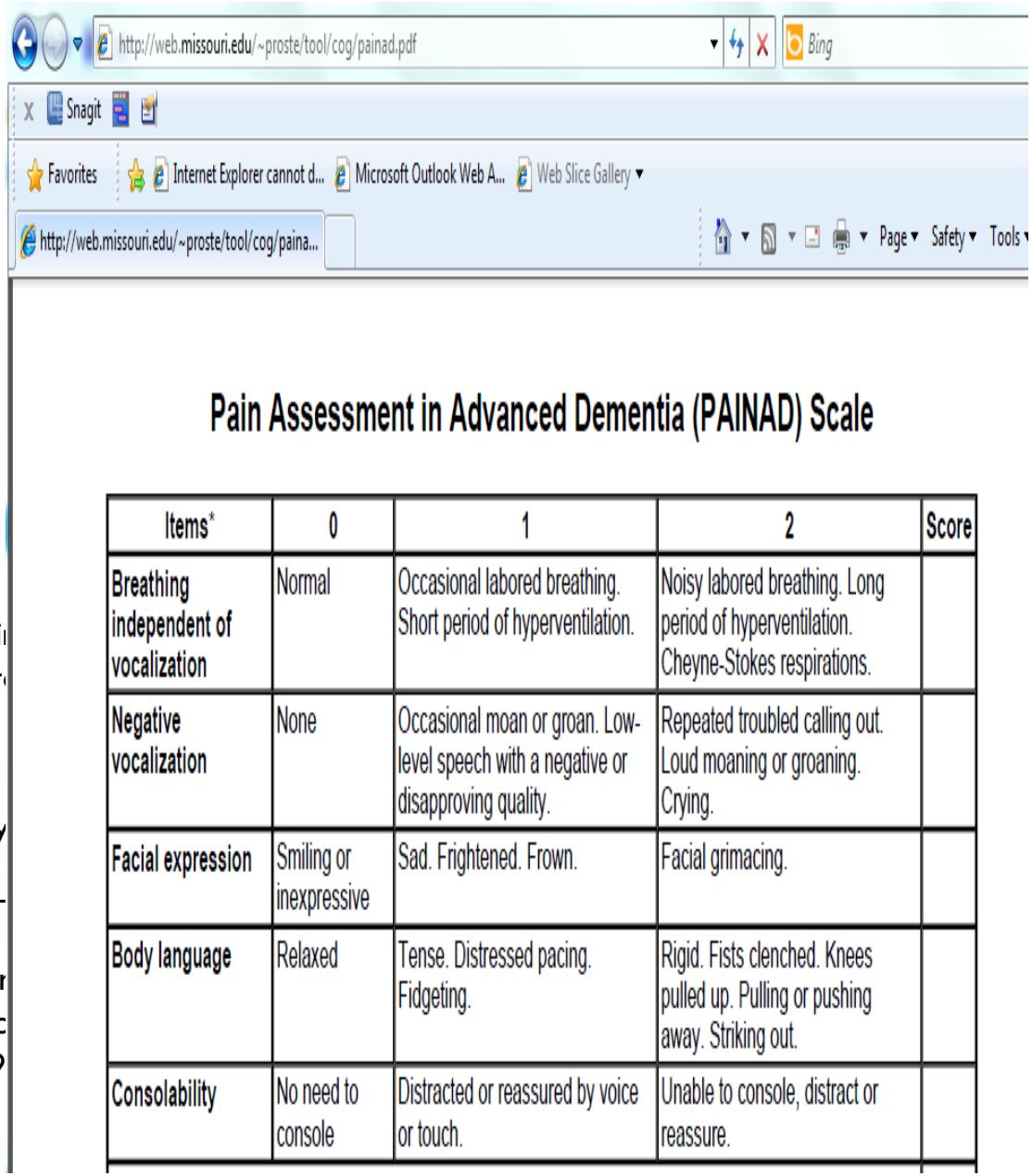
Sad Facial Expression: troubled look on face, looking hurt, worried, lost, or lonesome; distressed appearance, sunken, "hound dog" look with lackluster eyes; tears, crying.		
Frightened Facial Expression: scared, concerned looking face; looking bothered, fearful, or troubled; alarmed appearance with open eyes and pleading face.		
Frown: face looks strained; stern or scowling look, displeased expression with wrinkled brow and creases in the forehead; corners of the mouth turned down.		
Lack of Relaxed Body Language: easy open handed position; looking of being in a restful position and may be cuddled up or stretched out; muscles look of normal firmness and joints are without stress; look of idle, lazy, or "laid back"; appearance of "just killing the day"; casual.		
Tense Body Language: extremities show tension;		

	Freq.	Duration	Intensity
	(5 min)	<1 min	High
		≥ 1 min	Low



PAIN-AD SCALE

- 5 item observation scale
- Total score 0 -10
- Based on ordinal scale of 0 – 2
- Able to objectively describe pai
  based on observations of sympt
  of pain
- Useful when patients cannot
  communicate pain levels reliably
- Warden, V., Hurley, A., Volicer, L
  Development and psychometric
  evaluation of the pain assessmer
  advanced dementia (PAINAD) sc
  J Am Dir Association. 2003; 4:9



Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	

PAIN ASSESSMENTS - TYPES

Table 2. Examples of Pain Assessments

Category	Examples
General pain assessments	Brief Pain Inventory (Keller et al., 2004; MD Anderson Center, 2021) Face, Legs, Activity, Cry, Consolability (FLACC) behavioral pain scale (Malviya et al., 2006; Merkel et al., 1997) McGill Pain Questionnaire (Kremer & Atkinson, 1981) Numeric Rating Scale (Ferreira-Valente et al., 2011) Pain, Enjoyment of Life and General Activity (PEG) scale (Krebs et al., 2009) Visual analog scale (Gift, 1989) Wong–Baker FACES Pain Rating Scale (Wong & Baker, 1988; Wong-Baker FACES Foundation, 2016)
Site-specific pain assessments	Disabilities of the Arm, Shoulder and Hand (Hudak et al., 1996) Oswestry Pain Disability Index (Fairbank & Pynsent, 2000)
Performance skills assessments	Central Sensitization Inventory (Mayer et al., 2012) Fear-Avoidance Beliefs Questionnaire (Waddell et al., 1993) Pain Catastrophizing Scale (Sullivan et al., 1995) Pain Coping Questionnaire (Reid et al., 1998) Pain Self-Efficacy Questionnaire (Nicholas, 2007) Self-Compassion Scale (Neff, 2003; Raes et al., 2011) Sensory Symptoms Checklist (Wild, 2010) Occupational Experience Profile (formerly the Daily Experiences of Pleasure, Productivity and Restoration Profile) (Atler, 2015; Atler et al., 2015)
Assessments validated for use with clients with pain	Canadian Occupational Performance Measure (Law, Baptiste, et al., 2019) Functional Disability Inventory (Kashikar-Zuck et al., 2011; Walker & Greene, 1991) Patient-Specific Functional Scale (Maugham & Lewis, 2010; Stratford et al., 1995)

OTHER ASSESSMENTS

Occupational Questionnaire

Roles Checklist

Activity Card Sort

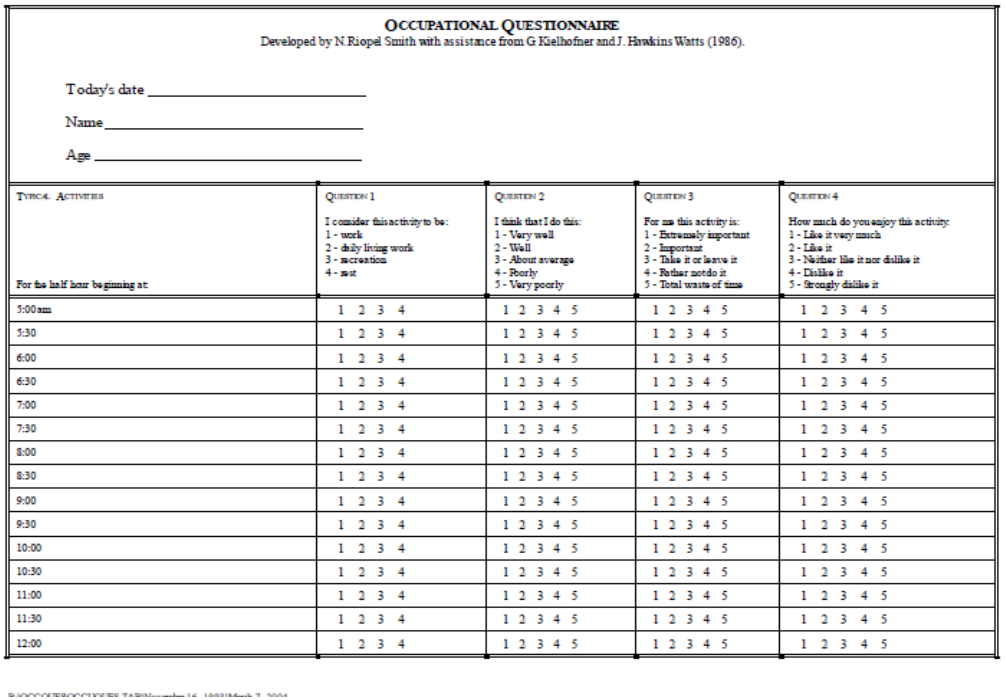
Patient Specific Functional Questionnaire

COPM

OCCUPATIONAL QUESTIONNAIRE (OQ) (1986)

http://www.uic.edu/depts/moho/images/Occupational%20%20Questionnaire.pdf

- Questionnaire or interview format
- Elicits information related to patient's volitic related to use of time
- Volition: values, interests, and personal causation
- Patient self report typical weekend and weekday routine for every 30 minutes of ti during a day
- Instrument provides a configuration of activ time-- % of time in work, play, daily living as well as % of time engaged in activities value, interest and that establish a send of ability or competence
- Smith, N.R., Kielhofner, G., & Watts, J. (19 The relatinships between volition, activity pattern, and life satisfaction in the elderly. American Journal of Occupational Therapy, 40(4), 278-283.



OCCUPATIONAL QUESTIONNAIRE

Developed by N.Riopel Smith with assistance from G Kielhofner and J. Hawkins Watts (1986).

Today's date _____

Name _____

Age _____

TYPICAL ACTIVITIES For the half hour beginning at:	QUESTION 1 I consider this activity to be: 1 - work 2 - daily living work 3 - recreation 4 - rest	QUESTION 2 I think that I do this: 1 - Very well 2 - Well 3 - About average 4 - Poorly 5 - Very poorly	QUESTION 3 For me this activity is: 1 - Extremely important 2 - Important 3 - Take it or leave it 4 - Rather not do it 5 - Total waste of time	QUESTION 4 How much do you enjoy this activity 1 - Like it very much 2 - Like it 3 - Neither like it nor dislike it 4 - Dislike it 5 - Strongly dislike it
5:00am	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
5:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
6:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
7:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
8:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
9:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
9:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
10:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
10:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
11:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
11:30	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
12:00	1 2 3 4	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

ROLE CHECKLIST

- Fran Oakley, MS, OTRL
- Questionnaire
- Can be orally administered or self administered
- Addresses a wide range of populations
- 2 Part Assessment
  - Role Participation
  - Value attributed to role
- Assists clinician in understanding roles that are important to the patient
- foakley@nih.gov
- Dickerson, A. E., (1999). The Role Checklist. In B.J. Hemphill-Pearson (Ed.), Assessment in occupational therapy mental health (p. 175-191). Thorofare, NJ: Slack

Email Fran Oakley – provide information in your email request – type of facility in which you work, type of clients served, City, State and County of Residence.

Also – accessible version available on the

ACTIVITY CARD SORT

- 89 photographs of well seniors performing variety of activities
- Assists in determining what occupational histories for patients look like
- Assists in defining goals, assess activities that have been given up lacking participation in
- Normative Data available for Cancer patients
- Baum, M.C., & Edwards, D.F. (200 Activity Card Sort. San Antonio , Harcourt Assessment.

CANADIAN OCCUPATIONAL PERFORMANCE MEASURE (COPM), 4TH EDITION 2005)

- Semi-structured interview
- Administered one on one
- Desired goal of the assessment tool is to determine a client's self perception of change in occupational performance – an outcome measure.
- This semi structured interview assists collaborative relationship to develop
- Commercially available tool
- Discussion centers around occupations categorized in three areas: self-care, productivity, and leisure. Patient describes active occupations as well as satisfaction with performance and areas that are problematic
- Outcome measure – so performance

Therapist reviews with patient most important problem and documents on the COPM interview form

Numerical measurement of performance and satisfaction graded

Performance and Satisfaction score obtained

PATIENT SPECIFIC FUNCTIONAL SCALE

- Neck Dysfunction
- Low back pain
- Knee Dysfunction
- Multiple Sclerosis

- Used to assess the ability to complete specific ta
- 11 point scale 0 -10 used to rate their ability to perform an activity
- "0" being unable to perform activity to "10" Ab perform activity at the same level as before the or problem
- Total score = sum of the activity scores / numbe activities
- Minimum detectable change is 2 points for aver score
- Minimum detectable change is 3 points for single activity score

Initial Assessment:

I am going to ask you to identify up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or having difficulty with because of your _____ problem? (Clinician: show scale to patient and have the patient rate each activity).

Follow-up Assessments:

When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list at a time). Today, do you still have difficulty with: (read and have patient score each item in the list)?

Patient-specific activity scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

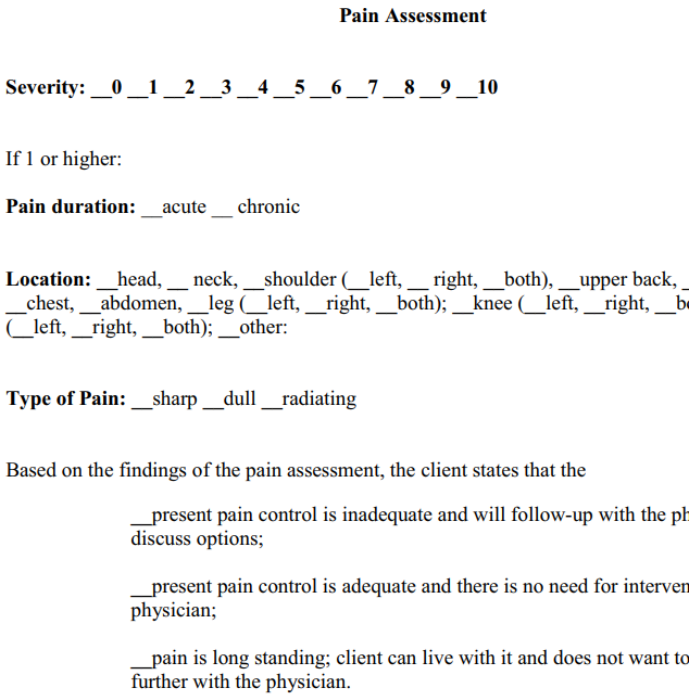
Able to perform activity at the same level as before

Westaway, M., Stratford, P., et al. (1998). "The patient-specific functional scale: validation of its use in persons with neck dysfunction." The Journal of orthopaedic and sports physical therapy 27(5): 331.
Find it on PubMed

Measure can be found on the Transport Accident Commision's website (external link)

ASHA RESOURCE

https://www.asha.org/siteassets/practice-portal/aatpainassessment.pdf



Pain Assessment

Severity: __0 __1 __2 __3 __4 __5 __6 __7 __8 __9 __10

If 1 or higher:

Pain duration: __acute __ chronic

Location: __head, __ neck, __shoulder (__left, __ right, __both), __upper back, _
__chest, __abdomen, __leg (__left, __right, __both); __knee (__left, __right, __b
(__left, __right, __both); __other:

Type of Pain: __sharp __dull __radiating

Based on the findings of the pain assessment, the client states that the

__present pain control is inadequate and will follow-up with the ph
discuss options;

__present pain control is adequate and there is no need for interven
physician;

__pain is long standing; client can live with it and does not want to
further with the physician.

Pain-Assessment & Monitoring Tools

From: Partners Against Pain®. Reviewed 2009.

This collection contains a number of helpful forms and assessment tools that can be downloaded and used to record pain intensity and duration, patient consent and treatment, clinical follow-up, and patient response to pain treatment. Among others, the following may be of special interest to healthcare providers...

Reviewer: Stewart B. Leavitt, MA, PhD. Access to all checked April 28, 2009.

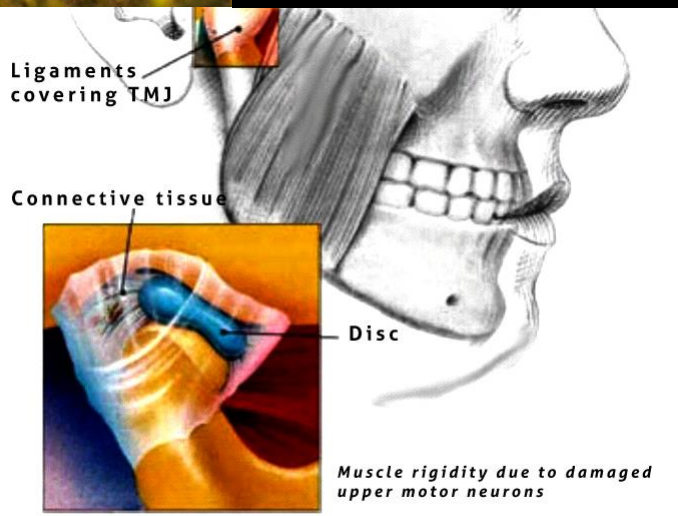
Pain Assessment Scales

> Visual Analog Scales (VAS)
> Numeric Pain Intensity Scale
> Simple Descriptive Pain Intensity Scale
> Graphic Rating Scale
> Verbal Rating Scale
> Pain Faces Scale
> Numeric Pain Intensity & Pain Distress Scales
> Brief Pain Inventory
> Memorial Pain Assessment Card (from Memorial Sloan-Kettering Cancer Center)

Go to: http://www.partnersagainstpain.com/professional-tools/pain-assessment-scales.aspx?id=3

WHAT ACTIVITIES EFFECT PAIN?

- What makes pain better or worse?
- Certain activities stress specific structures
- Are activities that effect pain consistent with history?



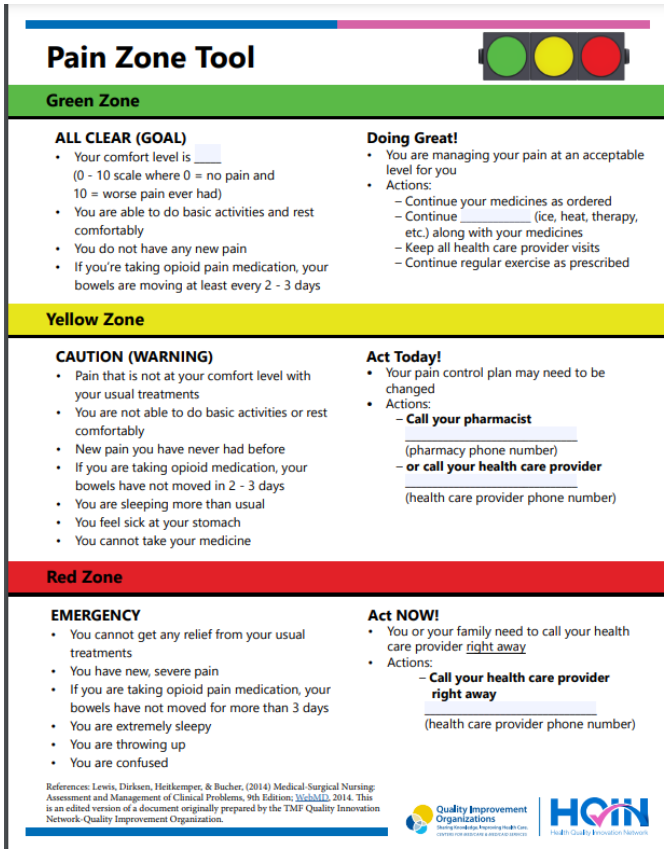
COMMUNICATION

Does patient have severe or intense pain?

Communicate with the patient and other health care providers. Patient may require pain medications before proceeding with evaluation and treatments.

TOOLS FOR EDUCATION

PAIN ZONE TOOL



Pain Zone Tool

Green Zone

ALL CLEAR (GOAL)

- Your comfort level is ____ (0 - 10 scale where 0 = no pain and 10 = worse pain ever had)
- You are able to do basic activities and rest comfortably
- You do not have any new pain
- If you're taking opioid pain medication, your bowels are moving at least every 2 - 3 days

Doing Great!

- You are managing your pain at an acceptable level for you
- Actions:
  - Continue your medicines as ordered
  - Continue _____ (ice, heat, therapy, etc.) along with your medicines
  - Keep all health care provider visits
  - Continue regular exercise as prescribed

Yellow Zone

CAUTION (WARNING)

- Pain that is not at your comfort level with your usual treatments
- You are not able to do basic activities or rest comfortably
- New pain you have never had before
- If you are taking opioid medication, your bowels have not moved in 2 - 3 days
- You are sleeping more than usual
- You feel sick at your stomach
- You cannot take your medicine

Act Today!

- Your pain control plan may need to be changed
- Actions:
  - **Call your pharmacist** _____ (pharmacy phone number)
  - **or call your health care provider** _____ (health care provider phone number)

Red Zone

EMERGENCY

- You cannot get any relief from your usual treatments
- You have new, severe pain
- If you are taking opioid pain medication, your bowels have not moved for more than 3 days
- You are extremely sleepy
- You are throwing up
- You are confused

Act NOW!

- You or your family need to call your health care provider right away
- Actions:
  - **Call your health care provider right away** _____ (health care provider phone number)

References: Lewis, Dirksen, Heitkemper, & Bucher, (2014) Medical-Surgical Nursing: Assessment and Management of Clinical Problems, 9th Edition; WebMD, 2014. This is an edited version of a document originally prepared by the TMF Quality Innovation Network-Quality Improvement Organization.

Quality Improvement Organizations | HQIN Health Quality Innovation Network

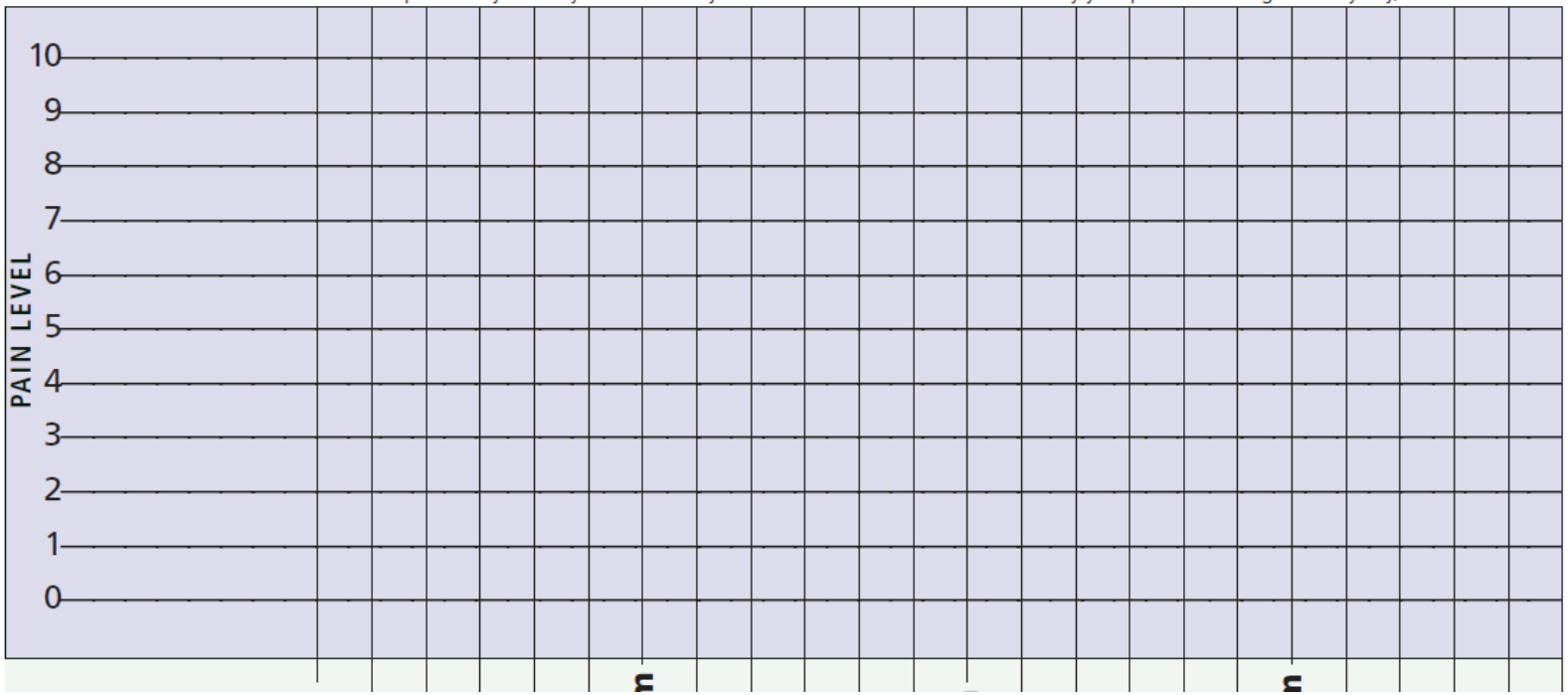
PATIENT EDUCATION

Name _____

Day _____

Date _____

1 DAILY PAIN CHART Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



PAIN COPING QUESTIONNAIRE

Description

The Pain Coping Questionnaire (PCQ) - Short Form is a self-administered 16-item questionnaire that includes subscales such as Problem Solving, Seeking Social Support, Cognitive Distraction, and Internalizing/Catastrophizing. The frequency of occurrence of each item is self-reported on a scale from 1 (Never) to 5 (Very Often). This protocol was validated in individuals aged 7- to 18-years-olds.

Name _____

Age (in years) _____ Sex (circle): Male Female Grade _____

Pain Coping Questionnaire - Short Form

Everyone has had a time when they have been hurt or in pain for a few hours or longer. For example, you might have had a headache, a stomach ache, a bad muscle pull, or pain in your joints (elbow, knee), an earache, or, for women, menstrual pain, etc… Below are some things that people might say, do, or think when they are hurt or in pain. We are interested in the things you do when you are in pain for a few hours or days.

Circle one word for each question to show how often you do each thing listed:

1 = never, 2 = hardly ever, 3 = sometimes, 4 = often or 5 = very often.

WHEN I AM HURT OR IN PAIN FOR A FEW HOURS OR DAYS, I …	***Never***	***Hardly Ever***	***Sometimes***	***Often***	***Very Often***
1) Say mean things to people.	1	2	3	4	5
2) Ask a nurse or doctor questions.	1	2	3	4	5

Pain Self-Efficacy Questionnaire

PAIN SELF EFFICACY QUESTIONNAIRE (PSEQ)

M.K.Nicholas (1989)

NAME: _____ DATE: _____

Please rate how **confident** you are that you can do the following things at present, **despite the pain**. To indicate your answer circle **one** of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

For example:

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

Remember, this questionnaire is **not** asking whether of not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

---

1. I can enjoy things, despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

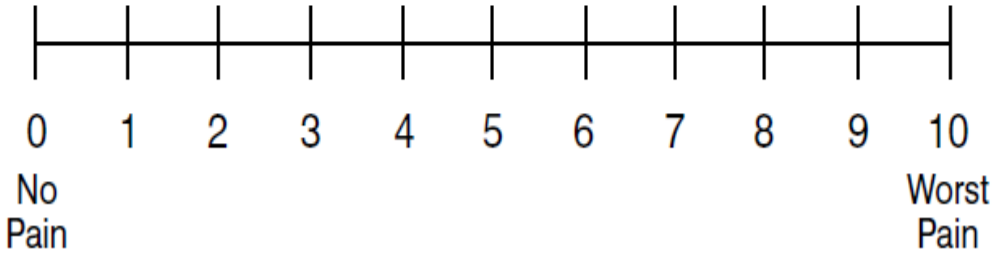
2. I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.

0	1	2	3	4	5	6
Not at all Confident						**Completely confident**

PAIN CONTROL LOGS

Pain Management Log

Please use this pain assessment scale to fill out your pain control log.

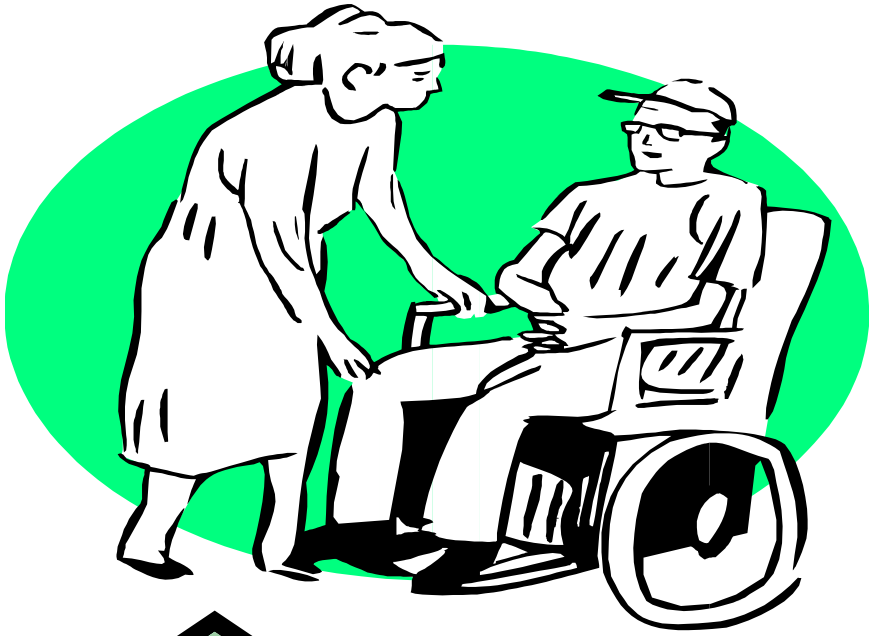


Date	Time	How severe is the pain?	Medicine or non-drug pain control method	How severe is the pain after one hour?	Activity at time of pain

WHAT TISSUES/STRUCTURES ARE INVOLVED?

- Systematically isolate and test structures
- Is there consistency with prior findings, subjective reports, mechanism of injury, etc.?

Back to Basics



Routine Meds
Alternative Therapies
Rehabilitation

PAIN MEDICATIONS

Is patient on pain medications?

Is dosage, frequency or type appropriate?

Would routine meds be appropriate?

Should you adjust schedule of therapy around pain medication schedule?

PAIN MEDICATION CONSIDERATIONS

When on analgesics:

- Evaluate when medication is wearing off

- Schedule treatment considerations

MEDICATION MANAGEMENT

Is the person responsible for their own administration of medication?

Are they accurately administering their medications?

Does the person need a standardized assessment to measure medication management skills?

Does the person understand abstract concepts associated with medication management?

TREATMENT APPROACHES

Restore Proper Alignment/Biomechanics

Protected Movement

Edema Reduction

Strengthening

Stretching

Modalities

Energy Conservation

Desensitization

Soft tissue mobilization

Joint mobilization

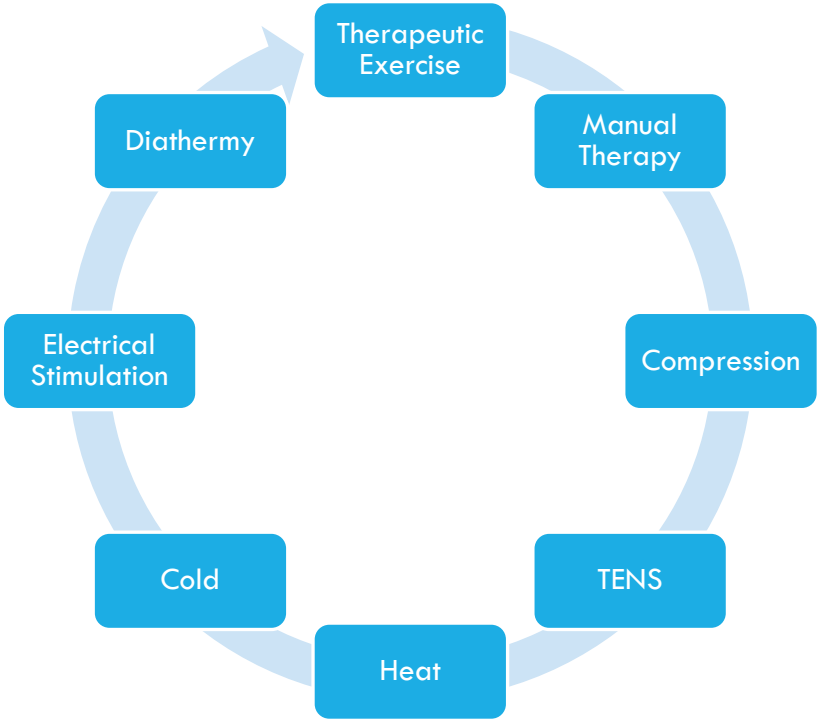
ADL retraining

Cognitive/psychosocial interventions

Behavioral interventions

Patient and Family Education

MODALITIES



Traction

Ultrasound

Soft tissue mobilization

Splints/braces

Orthopedic shoes/inserts

Taping

Iontophoresis

Infrared

RELAXATION

- Pain medicines only reduce pain by 30% on average
- Pain is stressful
- Relaxation – a bath, funny movie or listening to music

MINDFULNESS

Act of intentionally focusing on the present moment

Remember – pain is unpleasant physical pain AND how one reacts to it

Separate yourself from your negative thoughts, feelings, and sensations

Formal mindfulness meditation - setting aside time to focus on one thing – breathing or a sensory experience

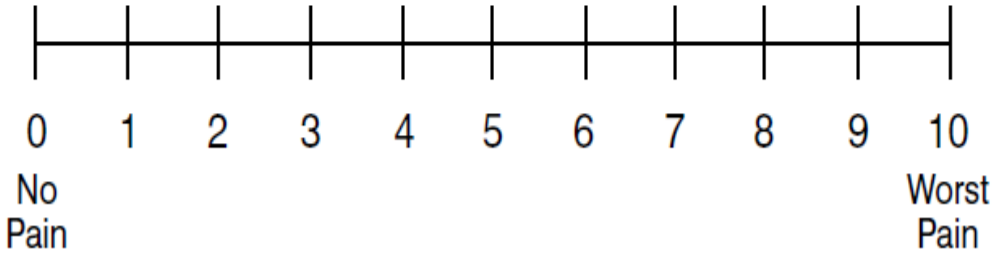
Start with 5 minutes – add a minute per day

Informal practice – focusing on the present moment during daily activities – example while eating – notice the taste, texture and smell of the food; spending time with loved ones, bring your full attention to the conversation or activity

PAIN CONTROL LOGS

Pain Management Log

Please use this pain assessment scale to fill out your pain control log.



Date	Time	How severe is the pain?	Medicine or non-drug pain control method	How severe is the pain after one hour?	Activity at time of pain

SUPPORT AND RESOURCES

MIpainManagement : www.michigan.gov/pm

PATH (Personal Action Toward Health) –www.MiPATH.org

Establishing a Support Group for Chronic Pain – JodyKohnMSW@comcast.net

H.O.P.E for Fibromyalgia – www.hffcf.org

QUESTIONS?