Pain assessment template

Name:

Address:

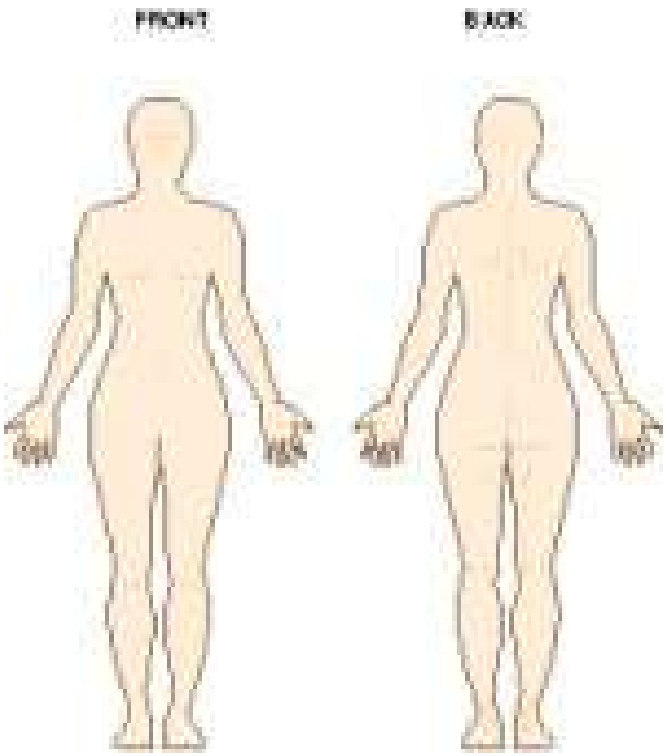
Hospital/clinic number:

Date of birth:

Duration of wound:

Plan of care at initial assessment (if known):

Brief description of wound:



Key aspects of assessment	Initial assessment Date: Assessor:	Reassessment Date: Assessor:	Reassessment Date: Assessor:
Assessment of pain: **1. Potential causes of persistent underlying wound pain at rest** For example: wound aetiology, infection, ischaemia, arthritis			
2. Signs of neuropathic pain For example: sharp, burning, tingling pain			
3. Location of wound pain (use body map) For example: local to wound, extending to surrounding area			
4. What makes the pain worse? For example: moving, night-time, tight dressings or bandages			

5. What dressing-related activities make the pain worse? For example: dressing removal/application, cleansing, leaving wound exposed			
6. What reduces the pain? For example: analgesia, leg elevation, warm environment			
7. What reduces the pain during or after dressing-related procedures? For example: removing own dressing, gentle touch, warm cleansing solutions, particular dressings			
8. Patient's feelings about wound and/or dressing-related procedures			
9. Pain intensity score <u>before</u> wound dressing-related procedure State pain scale used			
10. Note indications that dressing-related procedure caused pain/tissue trauma For example: dressing adheres to wound, bleeding			

Interventions to manage pain: **11. Cleansing agent and technique** State rationale for choice			
12. Dressing choice(s) State rationale for choice			
13. Methods used to secure dressing For example: adhesive tape, retention bandage			
14. Care of skin surrounding wound For example: emollients, the use of atraumatic dressings			
15. Analgesia consider For example: paracetamol, non-steroidal anti-inflammatory drugs, opioids; gas and air during procedure; anti-epileptics or anti-depressants for neuropathic pain			
16. Other strategies used to relieve pain For example: patient removes dressing, distraction techniques, time out during procedure			
17. Pain intensity score during wound dressing-related procedure			

18. Indications that patient is experiencing pain For example: grimacing, clenching fists, crying out, pallor, sweating			
19. Pain intensity score <u>after</u> wound dressing-related procedure			
20. Time taken for pain to resolve after dressing change/procedure			
21. Changes made to reduce pain at dressing-related procedures			
Signature of assessor			

Date for full reassessment: (assessment should be on-going)

Pain assessment rationale

Key aspects of assessment	Rationale
Assessment of pain: **1. Potential causes of persistent underlying wound pain at rest** For example: wound aetiology, infection, ischaemia, arthritis	Once potential causes of persistent, underlying wound pain are identified they may be more effectively managed. However, persistent pain may be due to associated pathologies that are not wound related.
2. Signs of neuropathic pain For example: sharp, burning, tingling pain	Neuropathic pain is difficult to identify and treat and is not restricted to patients with diabetic foot ulcers. Minimising neuropathic pain depends on early identification and specific treatment, such as appropriate medication.
3. Location of wound pain (use body map) For example: local to wound, extending to surrounding area	Spinal cord responses to pain signals may cause abnormal sensitivity of the surrounding soft tissue. This can be very uncomfortable and may be stimulated by the gentlest touch. Use the body map to indicate if there is more than one painful area.
4. What makes the pain worse? For example: moving, night-time, tight dressings or bandages	It is important to identify and avoid known pain triggers. This information may help to establish the aetiology of the patient's wound.
5. What dressing-related activities make the pain worse? For example: dressing removal/application, cleansing, leaving wound exposed	Avoid any unnecessary stimulus to the wound, such as swabbing the wound surface, excessive use of tape, the application of tight retention bandages or prolonged exposure of the wound.

6. What reduces the pain? For example: analgesia, leg elevation, warm environment	It is important to identify and use strategies that help reduce pain. These are individual by nature.
7. What reduces the pain during or after dressing-related procedures? For example: removing own dressing, gentle touch, warm cleansing solutions, particular dressings	Taking adequate time during dressing procedures can help to reduce patient anxiety and may prevent rough handling of the wound and surrounding tissues.
8. Patient's feelings about wound and/or dressing-related procedures	The impact of pain should be explored by listening to the patient's feelings and expectations of pain. The specific words they use to describe pain can suggest which type of pain they are experiencing. Simple questions such as 'Where do you believe the pain comes from?' and ' What helps you cope with the pain?' can be useful.
9. Pain intensity score <u>before</u> wound dressing-related procedure State pain scale used	Measuring pain intensity is one of the basic principles of pain assessment and acts as a baseline. The same pain scale should be used throughout a care episode to ensure consistency.
10. Note indications that dressing-related procedure caused pain/tissue trauma For example: dressing adheres to wound, bleeding	Once identified, these should be avoided where possible. Dressings that adhere to the wound surface should be reviewed with the aim of providing a more suitable alternative, for example the use of soft silicone dressings.
<u>Interventions to manage pain</u>: **11. Cleansing agent and technique** State rationale for choice	Cleansing agents containing antiseptics may cause discomfort and generally should be avoided. Warmed normal saline is the cleanser of choice. Gentle irrigation is usually less painful than swabbing the wound surface, but high pressure irrigation can be painful.

12. Dressing choice(s) State rationale for choice	The following parameters should be considered (1): • maintenance of moist wound environment • atraumatic to the surrounding skin • absorbency capacity • allergy potential. Dressings that promote moist wound healing generally cause the least trauma on removal, for example hydrogels, hydrocolloids or soft silicone dressings.
13. Methods used to secure dressing For example: adhesive tape, retention bandage	Hypersensitivity of the nerve endings in the area surrounding a wound can make adhesive tapes and dressings painful to remove. Retention bandages need to be applied carefully and regularly rechecked as oedema formation may lead to constriction and additional trauma.
14. Care of skin surrounding wound For example: emollients, the use of atraumatic dressings	If the wound is dry, dressings may adhere to newly formed epithelial tissue or dried exudate at the wound margins. Excessive exudate production may cause excoriation and/or maceration. Reddening of the surrounding skin (erythema) may indicate wound infection.
15. Analgesia consider For example: paracetamol, non-steroidal anti-inflammatory drugs, opioids; gas and air during procedure; anti-epileptics or anti-depressants for neuropathic pain	The World Heath Organization has developed a three-step analgesia ladder suitable for use in controlling background pain (2). Non-steroidal analgesics are the first step. Mild opioids should then be added or used alone. The final step is the use of strong opioids after reassessment of the previous approaches.
16. Other strategies used to relieve pain For example: patient removes dressing, distraction techniques, time out during procedure	Explain all procedures to the patient in a calm, unhurried manner. Allow sufficient time to perform the dressing-related procedure. Involve the patient throughout the procedure, for example patients may prefer to remove the dressing themselves or have time out.

17. Pain intensity score <u>during</u> wound dressing-related procedure	Uncontrolled pain during dressing changes should necessitate changes in the management regime. Pain rated as 'moderate' or scores above 4 on a scale of 1-10 are generally considered unacceptable.
18. Indications that patient is experiencing pain For example: grimacing, clenching fists, crying out, pallor, sweating	Many people find it difficult to verbally express pain. Non-verbal cues can be helpful when assessing pain in all patients but especially young children, the elderly or those with cognitive impairment. The patient's feelings should be respected and believed.
19. Pain intensity score <u>after</u> wound dressing-related procedure	The figure on pain scores is less important than the direction it is moving in. If pain scores are reducing, then pain management strategies are appropriate. It is useful to record pain scores graphically so that trends may be identified over time.
20. Time taken for pain to resolve after dressing change/procedure	Pain can linger for some time after dressing-related procedures. It is worth considering the timing of dressing changes so that this can be taken into account.
21. Changes made to reduce pain at dressing-related procedures	An ongoing review should be performed so that the strategies used to reduce pain can be evaluated and documented.
Signature of assessor	

Date for full reassessment: (assessment should be on-going)

References:

1. World Union of Wound Healing Societies. *Principles of best practise: Minimising pain at wound dressing-related procedures. A consensus document*. London: MEP Ltd, 2004. Available from URL: http://www.wuwhs.org

2. World Health Organization. *Cancer Pain Relief with a Guide to Opioid Availablity (Second Edition)*. Geneva: WHO, 1996.