Pain is a personal, individual and subjective experience. Pain is complex and dynamic and is not just a simple response to an unpleasant sensation (Dowding et al 2016); therefore, its assessment and management is challenging (Bond and Simpson 2006). Chronic pain may not be related to a specific cause and is challenging to localise (Bond and Simpson 2006). Chronic pain can develop if acute pain is not managed effectively, and is associated with a reduced quality of life, disability, anxiety and depression (Pearce 2019). It is important for healthcare professionals to be able to recognise the patient’s emotional response as well as their physical response when individuals who live with chronic pain experience acute pain (Pearce 2019). This article focuses on acute pain, discussing its recognition and assessment in hospital settings.

Defining pain
There are several definitions of pain. One seminal definition of pain is that of McCaffery (1968), who stated that pain is ‘whatever the experiencing person says it is, existing whenever and wherever the person says it does’. This definition is widely quoted by nurses and it encompasses the subjectivity and individuality that makes experiencing pain unique for every person.
The International Association for the Study of Pain (2017) definition of pain is also commonly used and describes pain as ‘an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’. This definition includes the emotional as well as physical aspects of pain, and attempts to describe the multifactorial nature of the pain experience.

Snow et al (2004) described four components of pain, which contribute to the understanding of its subjectivity and complexity. These components are:

» Sensory – the body’s physical response to noxious stimuli (actually or potentially tissue-damaging events), providing the intensity, character and location of the pain.

» Emotional – an individual’s emotional response to the pain, for example fear, depression, and anxiety.

» Behavioural – how the pain affects an individual’s activity, movement and facial expressions, for example wincing and grimacing.

» Cognitive – how an individual copes with and tolerates pain. The sensory, affective and cognitive components of pain are felt internally by the individual; therefore, nurses can only observe the behaviour the patient displays. To begin to appreciate the patient’s pain experience, the nurse should ask them questions, for example ‘Where is the pain located?’, ‘How does the pain make you feel?’ and ‘What coping mechanisms might you use?’

The pain management process includes the recognition and assessment of pain, provision of appropriate interventions, and evaluation of these interventions with the individual to ensure that they are effective and appropriate (Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine 2015). Nurses have an essential role in pain assessment and management because of their consistent and close relationship with patients (Brown 2011). Pain cannot be managed effectively if it is not recognised and assessed (Karcioğlu et al 2018); therefore, this is a fundamental aspect of the nurse’s role (Briggs 2010, Hall and Gregory 2016). A comprehensive pain assessment is required to ensure that pain management interventions are effective in reducing pain and improving patient outcomes.

### Pain assessment tools

Because of the subjective nature of pain, the most effective method for establishing if a patient is in pain is to ask them about their pain experience. One framework often used by healthcare professionals is the SOCRATES mnemonic, which provides a structured and systematic approach to assessment of the physical aspects of pain. The elements of the SOCRATES mnemonic are outlined in Box 1.

Pain assessment using the SOCRATES mnemonic focuses on the physical or sensory aspects of pain; the questions do not consider the emotional effects of the pain on an individual, for example fear, anxiety and depression. These emotional effects will influence how an individual copes with their experience of pain (Snow et al 2004).

Pain assessment tools that are more holistic than the SOCRATES mnemonic include the McGill Pain Questionnaire (Melzack 1975), which also asks how the pain affects an individual emotionally, and the Brief Pain Inventory (Cleeland and Ryan 1994), which includes assessment of how the pain affects the individual’s ability to undertake activities and their quality of life. These assessments of pain are detailed and take some time to complete, and therefore they tend to be used by specialist teams, such as palliative care teams and chronic pain services.

#### Pain scales

Pain scales provide a standard means of assessing pain intensity, usually in the form of a pain score. These scales are used to support patients to communicate their pain experience. They can also provide a consistent means of measuring and documenting pain, and assist in evaluating the effectiveness of any pain management interventions, indicating when a review of these interventions is required (Williamson and Hoggart 2005, Briggs 2010). Several valid and reliable pain scales are available. Examples of commonly used valid scales include the Numerical Rating Scale (NRS), Verbal Descriptor Scale (VDS) and Numerical Verbal Descriptor Scale (NVDS) (Williamson and Hoggart 2005, Karcioğlu et al 2018).

The NRS involves the individual rating their pain on a scale from 0-10, with 0 indicating ‘no pain’ and 10 indicating ‘the worst pain imaginable’ (Williamson and Hoggart 2005). The NRS is sometimes rated from 1-10, with 10 being ‘the worst pain experienced’. However, starting the scale at 1 does not provide an opportunity for ‘no pain’ to be scored and having a ‘worst pain experienced’ rating could lead to a score of more than 10 if the patient’s pain experience is more intense than any pain they have felt before.

The VDS uses words to describe pain, which commonly include: ‘no pain’, ‘mild pain’, ‘moderate pain’ and ‘severe pain’. The NVDS adds a number to the descriptive word used, whereby 0 is no pain, 1 is mild pain, 2 is moderate pain and 3 is severe pain. It has been suggested that the use of words to describe pain is appropriate for people with

### Box 1. SOCRATES mnemonic for pain assessment

<table>
<thead>
<tr>
<th>Component</th>
<th>Question</th>
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<tbody>
<tr>
<td>Site</td>
<td>Where is the pain?</td>
</tr>
<tr>
<td>Onset</td>
<td>When did the pain start? Was it sudden or gradual?</td>
</tr>
<tr>
<td>Radiation or referred pain</td>
<td>Does the pain go anywhere else?</td>
</tr>
<tr>
<td>Associated symptoms</td>
<td>Are there any other signs and symptoms associated with the pain, such as nausea or sweating?</td>
</tr>
<tr>
<td>Timing</td>
<td>Is the pain any better or worse in the morning? Does it increase during the day?</td>
</tr>
<tr>
<td>Exacerbating or relieving factors</td>
<td>Does anything change the pain? For example, is it worse after eating, or better when at rest?</td>
</tr>
<tr>
<td>Severity or intensity</td>
<td>How bad is the pain? This is usually measured using a pain scale</td>
</tr>
</tbody>
</table>
mild cognitive impairment (Herr 2011, Corbett et al 2014). One study found that 60% of people living with dementia could rate their pain using the NRS, compared with 90% of people living with dementia using the VDS (Lukas et al 2013). The Royal College of Physicians (RCP) et al (2007) recommended the use of verbal descriptors to assess pain in older people, and suggested that alternative words to pain could be used, for example ‘hurt’ or ‘ache’.

There is no evidence to indicate that one pain scale is superior or to suggest which pain scale should be used (Hjermstad et al 2011); the pain scale used appears to be decided by the healthcare organisation or individual healthcare professionals. In a small pilot survey, Gregory and Richardson (2014) found that the pain scales used varied across healthcare organisations, and that the NRS was the most commonly used, although the VDS and NVDS were also used. The NRS may be the most commonly used because it is quick and easy to use, valid and reliable, and allows for small changes in pain intensity. Individual nurses indicated that they used one or more pain scale in their clinical practice, depending on the patient and their abilities and preferences (Gregory and Richardson 2014). These findings are supported by Karcioğlu et al’s (2018) systematic review, which examined 19 studies that compared pain scales used in a range of settings with various patient groups. Some of these studies indicated that the NRS is the scale preferred by healthcare professionals, although older patients often preferred the VDS (Karcioğlu et al 2018).

**Limitations of pain scales**

A pain score attempts to measure the intensity of pain, and in hospital settings these scores are often incorporated into the patient’s physiological observations, enabling a record of their pain to be documented. In the late 1990s, pain was advocated as the ‘fifth vital sign’, to emphasise that it is as important as documenting physiological observations. This aimed to raise nurses’ awareness of pain and how it might be a reason for changes to other vital signs, such as heart rate and respiratory rate. However, in practice, this reduces a pain assessment to one question about pain intensity only and has led to interventions that are based on this limited measure of pain (PAINS Project 2017). It is crucial that pain is not just considered as a number on the patient’s observation chart (Briggs 2010, Gregory 2017a).

Identifying and assessing pain is more complex than simply obtaining a pain score. Interpretation of data from the pain scale is not straightforward, since the significance of the pain score will depend on previous scores to evaluate pain interventions (Williamson and Hoggart 2005). Furthermore, reliance on a pain score alone will not provide comprehensive information about an individual’s pain and, as with all assessment tools, pain scales should not be used in isolation and should be considered alongside other factors. A comprehensive, holistic and systematic pain assessment should consider the various aspects that might influence an individual’s experience of pain.

**Importance of communication**

When using a pain scale, the patient needs to be able to communicate and describe their pain experience, and to understand the questions and pain scale that is used. It is also important for healthcare professionals to listen and interpret descriptions and the pain score provided by the patient. Therefore, assessment of pain requires effective communication skills.

Some patients may find communication challenging for various reasons, including language barriers, hearing impairment, cognitive impairment and dementia. The Royal College of Physicians (RCP) et al (2017) have recommended that one pain scale is superior to interventions that are based on a simple response to an unpleasant sensation; therefore, its assessment and management is challenging.

**Key points**

- Pain is complex and dynamic and is not just a simple response to an unpleasant sensation; therefore, its assessment and management is challenging.
- The pain management process includes the recognition and assessment of pain, provision of appropriate interventions, and evaluation of the interventions with the individual to ensure that they are effective and appropriate.
- Because of the subjective nature of pain, the most effective method for establishing if a patient is in pain is to ask them about their pain experience.
- Some patients may find communication challenging for various reasons, including language barriers, hearing impairment, cognitive impairment and dementia.
- Observational pain assessment tools have been developed to provide a systematic and consistent approach to the assessment of pain. Most of these tools have been developed within nursing homes (long-term care) and for people living with dementia.

**Observational pain assessment tools**

One of the components of pain described by Snow et al (2004) is behaviour. In general, healthcare professionals observe patients to confirm what they have reported about their pain. Attempts have been made to identify behaviours that consistently indicate pain. For example, if the patient is grimacing and holding or rubbing a particular area of their body and appears tense, this is likely to indicate that they are in pain, whereas if the patient is smiling and appears relaxed, this indicates they are less likely to be in pain. However, it has also been suggested that pain behaviours are individual. The American Geriatrics Society Panel on Persistent Pain in Older Persons (2002) produced six categories of common pain behaviours that can

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indicate pain in older people who are cognitively impaired:

- Facial expressions, for example grimacing, frowning, appearing frightened, or closed or tightened eyes.
- Verbalisations or vocalisations, for example sighing, moaning, shouting, asking for help or loud breathing.
- Body movements, for example tense posture, fidgeting, increased pacing, rocking or changes in gait or mobility.
- Changes in interpersonal interactions, for example becoming aggressive or disruptive, resisting care, decreased social interactions or becoming withdrawn.
- Changes in activity patterns or routines, for example changes in appetite or sleep pattern, increased periods of rest or sudden cessation of common routines.
- Changes in mental status, for example crying, irritability, distress or increased confusion.

Observing any one of these behaviours alone may not indicate pain, but observing a combination of these behaviours should lead to a suspicion that the individual is in pain.

Traditionally, nurses have identified pain in patients with communication difficulties based on their clinical experience and knowledge of the patient’s diagnosis, behaviour, physiological measures and any physical injury. This was confirmed by Dowding et al (2016), who found that nurses described using their clinical experience to assess pain and that they distrusted observational pain assessment tools.

Observational pain assessment tools have been developed to provide a systematic and consistent approach to the assessment of pain. Most of these tools have been developed within nursing homes (long-term care) and for people living with dementia. Therefore, it is important to consider which tool is the most appropriate for the patient population and healthcare setting.

In the UK, commonly used observational pain assessment tools include: the Abbey pain scale (Abbey et al 2004); the Pain Assessment in Advanced Dementia (PAINAD) scale (Warden et al 2003); the Doloplus-2 (Hølen et al 2007); and the Bolton Pain Assessment Tool (BPAT) (Gregory 2012). An overview of these tools is provided in Table 1.

The Abbey pain scale (Abbey et al 2004) was devised in nursing homes in Australia and was recommended by the RCP et al (2007), leading to its widespread adoption across various healthcare settings, despite a lack of testing within these settings and any recent evaluations. The rating of pain is subjective, with the assessor rating each category as absent (0), mild (1), moderate (2) or severe (3).

The PAINAD scale (Warden et al 2003) was devised and tested on 19 men with advanced dementia in a long-term care setting. Its format and scoring are clear, and descriptions of the behaviours are provided to assist in rating the patient’s pain. It has been tested

<table>
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<tr>
<th>Table 1. Overview of commonly used observational pain assessment tools</th>
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<tr>
<td>Pain assessment tool</td>
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<tr>
<td>Pain Assessment in Advanced Dementia (PAINAD) scale (Warden et al 2003)</td>
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<tr>
<td>Abbey pain scale (Abbey et al 2004)</td>
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<tr>
<td>Doloplus-2 (Hølen et al 2007)</td>
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<tr>
<td>Bolton Pain Assessment Tool (BPAT) (Gregory 2012)</td>
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in hospital settings, leading to its use in some acute care settings (Sampson et al. 2015).

The Doloplus-2 (Hølen et al 2007) is a detailed assessment tool that has been researched extensively and translated into various languages. However, in the author’s experience, it does not appear to be used in everyday clinical practice; this may be because of the large number of factors that need to be observed.

The BPAT (Gregory 2012) was developed in an acute hospital setting. It includes six categories and descriptions of behaviours that indicate pain, combining aspects of the Abbey pain scale and the PAINAD scale. The BPAT is the only one of these observational pain assessment tools to include a section or prompt to ask a relative or significant other to suggest specific individual behaviours that indicate pain. Initial testing has suggested that the BPAT is quick and easy to use, and leads to pain management interventions as well as administering and reviewing analgesics, as well as the use of comfort measures (Gregory 2017b). It was also identified that the tool enables carers to provide useful information about the patient’s pain behaviours (Gregory 2017b).

Evidence base
Several reviews have examined some of the observational pain assessment tools available. They have identified a lack of consistent, robust validity and evaluation data; therefore, there remains a need to establish if these tools are useful in assessing pain, or if the behaviours observed indicate distress instead (Herr 2011, Corbett et al 2014). Corbett et al (2014) concluded that observational pain assessment tools lack feasibility in practical practice, because issues related to their practical application, such as the number of factors required and the time needed to complete the tool, may result in them not being used in everyday practice. Ultimately, the healthcare professional’s choice of which observational pain assessment tool to use will depend on the patient population and the usefulness of the tool (Herr 2010).

Conclusion
Pain is complex because of its subjective nature; it is an individual experience that may be influenced by various factors such as the severity, character, and site of the pain. As a result, it is important that the individual is able to express and describe their experience of pain. Pain scales are an accepted method for measuring pain intensity, although pain scores should be confirmed by observation of physiological measures and behaviours associated with pain. When the individual cannot communicate their pain experience, these observations of behaviour can form the foundation of a pain assessment, and they have been incorporated into various observational pain assessment tools in an attempt to ensure that the assessment is consistent.

The assessment of pain is an essential aspect of the nurses’ role in pain management. Nurses should ensure that, in addition to asking patients for a pain score, they consider what other factors might influence their experience of pain, and ask how the pain is affecting them emotionally as well as physically.

References


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The importance of pain management in older people with dementia. British Medical Bulletin. 111, 1, 139-148.


