Patient Pain Assessment and Management
Patient Safety Bulletin Number 4

A Joint Statement of the American Academy of Ophthalmology, the American Society of Ophthalmic Registered Nurses, and the American Association of Eye and Ear Hospitals

Background

In January 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented pain assessment and management standards and began to assess compliance.[1] The Joint Commission's development of standards on pain assessment and management originated from a collaborative effort, funded by the Robert Wood Johnson Foundation, to make pain assessment and management a health care priority. These standards on pain assessment and management apply to all accredited health care organizations, and compliance with both the standard and the intent is assessed through interviews with patients and staff, review of policies, clinical records, educational materials, etc. This arises from the belief that alleviation of pain is a core responsibility of health care providers. Application of the JCAHO's pain assessment and management standards is intended to increase the likelihood that patients will have their pain evaluated in a prompt fashion and treated appropriately.

The first step in the process is that patients are screened for physical pain. If pain is detected or described, then the organization's staff can assess and treat the pain, assess the pain and refer for treatment, or refer the individual for assessment and treatment.

Excerpts of the New Joint Commission Pain Assessment and Management Standards

Patient Rights and Organizational Ethics

Standard RI.1.2.7
Patients have the right to appropriate assessment and management of pain.

Intent of RI.1.2.7
The organization plans, supports and coordinates activities and resources to assure the pain of all individuals is recognized and addressed appropriately. This includes:

- Initial assessment and regular reassessment of pain
- Education of relevant providers in pain assessment and management
- Education of patients and families when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments; and
- After taking into account personal, cultural, spiritual and/or ethnic beliefs, communicating to patients and families that pain management is an important part of care.

Assessment of Patients

Standard PE.1.4
Pain is assessed in all patients.

Intent of PE.1.4
In the initial assessment, the organization identifies patients with pain. When pain is identified, the patient can be treated within the organization or referred for treatment. The scope of treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by the patient's condition. This assessment and a measure of pain intensity and quality (e.g., pain character, frequency, location, duration) appropriate to the patient's age, are recorded in a way that facilitates regular reassessment and follow up according to the criteria developed by the organization.

Care of Patients/Operative and Other Procedures

Standard TX.3.3
Policies and procedures support safe medication prescribing or ordering.

Intent of TX.3.3
Procedures supporting safe medication prescription or ordering address (relating to pain):

Appropriate use of patient-controlled analgesia (PCA), spinal/epidural or intravenous administration of medications and other pain management techniques in the care of patients with pain

Standard TX.5.4.6
The patient is monitored throughout the postprocedure period, with specific attention to pain intensity and quality and responses to treatment.

Intent of TX.5.4.6
The following items are monitored (relating to pain):

Pain intensity and quality (for example, pain character, frequency, location, duration and responses to treatments)

Education of Patients and Family

Standard PF.3.4
Patients are educated about pain and managing pain as part of treatment, as appropriate.

Intent of PF.2.5
When appropriate, patients and families are instructed about understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management, when identified as part of treatment.

The initial assessment of pain can be quite involved and involve the use of more than one pain intensity measures. Examples of implementation are included in Appendix A.

Definition of the Problem

In 2001, as these standards were first being implemented and surveyors assessed hospitals, it was assumed that all outpatients needed a pain assessment at each visit, documented in the medical charts. This was also applied to ambulatory ophthalmic clinics, and surveyors were recommended that all ophthalmic outpatients have a systemic pain assessment performed on each visit. However, it does not seem feasible nor productive for all ophthalmic patients to be assessed for systemic pain. Most patients already have a primary care provider, who is best equipped to assess and manage their systemic pain problems. Patients would also not expect to be queried about or share their systemic pain issues with their ophthalmologists. Ophthalmologists are best qualified to assess patients' ocular pain, diagnose the etiology of the pain, treat the disease condition, and manage the pain appropriately.

Ophthalmic patients who present with a need for refraction, new contact lenses or glasses, or eye infections typically do not have any related systemic conditions that could cause pain. Instead, pain assessment and management should be

targeted at those groups of ophthalmic patients whose disease condition warrants pain evaluation as part of the presenting symptomatology or as a signal of a complication of care, and whose status after a procedure, such as cataract surgery, warrants pain management to relieve suffering and quicken recovery.

For some ophthalmic patients, ocular pain is a significant factor and ocular pain management is an integral part of patient management. For example, in cataract surgery and other ophthalmic surgeries, anesthesia strategies have produced excellent pain management. In a large multi-center study of routine medical testing before cataract surgery, 19,250 patients rated their satisfaction with pain management and pain during surgery.[2] Ninety-five percent of patients reported no pain during surgery and ninety-seven percent were very satisfied with their pain management after surgery. In these circumstances, ocular pain assessment and management, if appropriate, are relevant and advance patient comfort.

Clarification of the JCAHO Standards

In discussions with the JCAHO standard implementation staff, the pain assessment and management standard was clarified as follows (based on the JCAHO manual)[3]:

1. That the JCAHO pain management standards are not intended to be applied for all outpatients.

2. That the standards were intended for the initial assessment of a patient, and not at every visit that a patient presents.

3. That the patient is assessed for pain if it is appropriate for the reason for presenting to the physician or health care institution. Not all new ophthalmic patients need to be evaluated for ocular pain.

4. That the scope of pain assessment is appropriate to the patient's clinical circumstances, i.e., an ophthalmologist would not be expected to perform a systemic pain assessment and management for a patient.

Suggestions for Improving Patient Safety

In institutions subject to the JCAHO pain assessment standards, if appropriate and relevant to their presentation, new ophthalmic patients should be evaluated for ocular pain. The following suggestions can help in assessing patients appropriately for pain, and minimizing any errors in how patients are handled:

1. Each institution develops a policy to identify when ocular pain assessment is appropriate and relevant for new ophthalmic patients, and should be performed and documented in the record.

   For example, groups of patients for which pain is a relevant sign or indicator and pain management is an important part of treatment might include the following:

   a. Patients with corneal ulcers and abrasions

   b. Ophthalmic surgical patients (these include inpatients and outpatients)

   c. Ophthalmic emergency and trauma patients

   d. Outpatients for examinations with severe infections and inflammations

This group of patients would then be asked about the intensity and quality of pain, educated, and a strategy for pain management would be developed.

2. Each institution develops an implementation strategy. (A sample is attached in Appendix A.[4] Many hospitals may have policies already in place.)

3. Each institution monitors implementation, and takes corrective action, if needed.

Developed by the AAO Quality of Care Secretariat in collaboration with ASORN and AAEEH. The American Academy of Ophthalmology, representing over 95% of practicing ophthalmologists in the United States, is committed to promoting high-quality eye care and its continuous improvement. The American Society of Ophthalmic Registered Nurses (ASORN) and the American Association of Eye and Ear Hospitals (AAEEH) are collaborative partners with the Academy's commitment to quality patient care and its ongoing quality of care activities. ASORN is a society of registered nurses whose mission is to foster excellence in ophthalmic patient care and to support the ophthalmic team through individual development, education, and evidence-based practice. AAEEH is composed of domestic and international institutions, which are dedicated to quality medicine, research, education and surgical excellence.

References

1. Joint Commission 2000-2001 Standards for Ambulatory Care Accreditation Policies, Standards, Intent Statements. 2000 by the Joint Commission on Accreditation of Healthcare Organizations.

2. Katz J, Feldman MA, Bass EB et al: Injectable versus topical anesthesia for cataract surgery: patient perceptions of pain and side effects. Ophthalmology 2000; 107;2054-60.

3. Personal Communication with staff of the Joint Commission for Accreditation of Health Care Organizations, October 16, 2001, Director of Standards Interpretation Group.

4. The Johns Hopkins Hospital Interdisciplinary Clinical Practice Manual: Pain Assessment and Management, PAT 025, April 25, 2001.

Appendix A

Sample Implementation for Standard PE.1.4 from the Joint Commission of Accreditation of Healthcare Organizations 2000-2001 Standards for Ambulatory Care Manual

Examples of Implementation for PE.1.4

1. All patients at admission are asked the following screening or general question about the presence of pain: Do you have pain now? Have you had pain in the last several months? If the patient responds "yes" to either question, additional assessment data are obtained:

    a. pain intensity (use a pain intensity rating scale appropriate for the patient population; pain intensity is obtained for pain at present, at worst, and at best or least; if at all possible, the pain rating scale is consistently used in the organization and between disciplines)

    b. location (ask the patient to mark on a diagram or point to the site of pain)

    c. quality, patterns of radiation, if any, character (elicit and record the patient's own words whenever possible)

    d. onset, duration, variations and patterns

e. alleviating and aggravating factors

f. present pain management regimen and effectiveness

g. pain management history (including a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, manner of expressing pain)

h. effects of pain (impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.)

i. the patient's pain goal (including pain intensity and goals related to function, activities, quality of life)

j. physical exam/observation of the site of pain

2. Patient often have more than one site of pain. An assessment system or tools with space to record data on each site is provided on the assessment sheet.

3. A hospital may need to use more than one pain intensity measure, depending on their patient population. For example, a hospital serving both children and adults selects a scale to be used with each of those patient populations. Assessment of cognitively impaired patients may also require assessment of behavioral factors signaling pain or discomfort.

4. Staff is educated about pain assessment and treatment including the barriers to reporting pain and using analgesics. Staff encourage the reporting of pain when a patient and/or family member demonstrates reluctance to discuss pain, denies pain when pain is likely to be present (for example, post-operative, trauma, burns, cardiac emergencies), or does not follow through with prescribed treatments.

5. Pain intensity scales are enlarged and displayed in all areas where assessments are conducted. For organizations using clinical pathways, pain assessment is incorporated in some way, into every appropriate clinical pathway.

An organization selects pain intensity measures to insure consistency across departments; for example, the 0-10 scale, Wong Baker FACES Pain

Rating Scale (smile-frown), and the Verbal descriptor scale. Adult patients are encouraged to use the 0-10 scale. If they cannot understand or are unwilling to use it, the smile-frown or the verbal scale is used.

A unit caring for persons with Alzheimer's disease developed a pain scale for each resident based on their long-standing knowledge of their residents and their knowledge of the common pain syndromes in elderly persons.

A pediatric hospital includes, in its introductory information for parents, information about pain and pain assessment, including parents' role in interpreting behavioral changes of their child that may indicate pain or discomfort.

The Johns Hopkins Hospital Interdisciplinary Clinical Practice Manual: Pain, assessment and Management, PAT 025, April 25, 2001

Approvals

American Academy of Ophthalmology, Quality of Care Secretariat, Hoskins Center for Quality Eye Care, 2001

American Society of Ophthalmic Registered Nurses (ASORN) and the American Association of Eye and Ear Hospitals (AAEEH), 2001

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