

INTRODUCING THE CLINICALLY ALIGNED PAIN ASSESSMENT (CAPA)

Primary Investigators: Penny Mclain RN CPAN, Theresa Nelson RN BSN CPAN Co-Investigator: Mary J Waldo PhD RN GCNS-BC
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BACKGROUND

Pain assessment is an essential first step in formulating a safe and effective pain management strategy. Asking a patient to rate their pain on a numeric rating scale (NRS) may not be the most reliable assessment of pain. Linking order sets to NRS could lead to an over reliance of narcotics to manage pain and in some instances, this may be harmful to the patient. Hospital policies frequently require patients reach an arbitrary number before transfer to another phase of care. An assessment tool that takes into account all aspects of the pain experience is vital to improving patient safety and satisfaction.

The CAPA tool, developed by Dr. Gary Donaldson at the University of Utah, seeks to elicit the additional qualities and functional impacts that require assessment when developing a pain management plan.

The Joint Commission (TJC) and the American Society for Pain Management Nursing (ASPMN) are in agreement that use of the NRS as the primary and only method for assessing pain places patients at risk for opioid overdose and non-effective treatment.

PURPOSE

To compare perceptions of the effectiveness of two pain assessment scales, CAPA and NRS, in post-surgical spinal patients staying at least one night in the neurovascular unit.

Clinical nurses are dissatisfied with using the NRS as the foundation for pain management. They voiced that it is difficult to explain to patients, and frequently encounter patients who struggle to assign a number to a multi-dimensional experience.

The current opioid crisis and the new TJC standards compels us to look for alternative ways to evaluate and manage pain.

METHODS

An IRB approved, prospective observational study was conducted. Patients undergoing elective spinal surgery who stayed at least one night in the hospital (n=40) were included, Nurses trained in the use of CAPA, assessed patients' pain levels first with CAPA then NRS. Patients completed a survey on discharge comparing their perception of CAPA and NRS in three categories: ease of use of each tool, nurse response to each tool and overall comfort with use of each tool.

DISCUSSION/CONCLUSIONS

Nurses frequently use CAPA language in the peri-anesthesia area to assess pain and establish a plan for pain management. Administering opioids strictly using the NRS scale without having that critical patient conversation, can lead to patient dissatisfaction and poor clinical outcomes. Often the experienced nurse realizes it is not just what the patient states their pain score is but rather how they appear clinically. In turn, a less experienced nurse may medicate to a high pain number without taking into consideration the medications already given, their duration of action, the potential for increasing sedation and that pain control is a continuum.

Changing a long standing practice of assigning a number to pain will take time. This study only looked at 40 patients on a neurovascular unit and did not include a nurse survey.

Further research to evaluate how CAPA effects pain management and patient/nurse satisfaction is warranted. Dr. Donaldson has encouraged further research using CAPA to add to its validity.

The results of this limited survey and frequent informal statements made by nurses strongly suggest that NRS may not be adequate for clinical practice.

RESULTS

Patient survey results show no significant difference between the numerical scale and the CAPA tool in ease of use by patients ($p > .05$). In addition, there was no significant difference between patients perception of nurse response between the two tools, ($p > .05$). However, there was a statistically significant difference in patient comfort level with the two tools ($p = .018$) with preference for CAPA.

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- 1. COMFORT**
 - Intolerable: In agony, "Can't think of anything else but pain"
 - Tolerable with discomfort: "Could be better," "Can take for a while, but couldn't go on like this too long"
 - Comfortably manageable: "Can handle it," "Still there if I think about it but not a big deal," "Nothing I can't handle"
 - Negligible pain: "Minimal or no pain," "Little or no pain," "Hardly any"
- 2. CHANGE**
 - Getting worse
 - About the same
 - Getting better
- 3. PAIN CONTROL**
 - Inadequate pain control
 - Effective, just about right
 - Would like to reduce medication [Why?]
- 4. FUNCTIONING** – for the usual things you need to do:
 - Can't do anything because of pain
 - Pain keeps me from doing most of what I need to do
 - Can do most things, but pain gets in the way of some
 - Can do everything I need to
- 5. SLEEP** – is the pain waking you up? Yes? No?
 - Awake with pain most of the night
 - Awake with occasional pain
 - Normal sleep

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