

# Pain Assessment

## Use of the Defense and Veterans Pain Rating Scale in patients with cancer

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**BACKGROUND:** Thorough, consistent pain assessment and reassessment are critical to guide and evaluate interventions designed to improve pain.

**OBJECTIVES:** Based on a literature review about functional pain assessment, clinicians selected and then implemented the Defense and Veterans Pain Rating Scale (DVPRS) as a pain assessment instrument option in a comprehensive cancer center.

**METHODS:** The DVPRS was added as a pain assessment instrument in clinical oncology practice. From postimplementation chart review and clinician satisfaction surveys, the DVPRS was evaluated for the following: improved communication among patients, nurses, and providers regarding patient pain intensity; consistency by nurses and providers when treating pain intensity (mild, moderate, or severe); and clinician satisfaction using the DVPRS to assess a patient's functional status along with pain intensity.

**FINDINGS:** Seventy-eight percent of nurses surveyed (N = 64) preferred the DVPRS over any other pain assessment tool. Inpatient and ambulatory patients surveyed (N = 144) agreed that a Likert-type scale in the DVPRS was easier to understand, easier to use, and better in describing their pain than the numeric rating scale.

### KEYWORDS

pain; pain assessment; Defense and Veterans Pain Rating Scale; cancer; functional status

### DIGITAL OBJECT IDENTIFIER

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**THE TREATMENT OF PAIN, A COMMON SYMPTOM OF CANCER,** is a priority of patient care (Running & Seright, 2012). Some studies estimate that as many as 90% of all patients with cancer experience pain (Eaton, Meins, Mitchell, Voss, & Doorenbos, 2015). Managing and living with pain is among the most common fears of patients with cancer. In one study, LeMay et al. (2011) surveyed 117 patients with advanced cancer who had received a referral for pain management and established that fear of pain was not only significant but also a significant predictor of a patient's functional limitations. Symptom management, including pain management, challenges physicians, oncology nurses, and patients themselves (Eaton et al., 2015; Klafke et al., 2016).

Pain is a subjective experience that cannot be measured objectively (American Pain Society, 2009). Pain quality and intensity are based on a patient's self-report. The clinical definition of pain is "whatever the experiencing person says it is, existing whenever he/she says it does" (McCaffery, 1968, p. 95). Since around 2000, the standard of care for pain assessment has used the numeric rating scale (NRS); however, the NRS requires some abstract thinking that may be difficult and confusing to patients (Tandon et al., 2016).

In the current climate of scrutiny of prescribing opioids and the prevalence estimate of 9% of Americans currently meeting the diagnostic criteria for substance use disorder (Compton & Chang, 2017), the use of a pain assessment tool that incorporates patients' functional status should be explored. This sort of tool would help make the case to patients that perhaps no pain is not the ultimate goal. The goals of pain intervention that must be made clear to patients are making the pain tolerable, continuing or increasing patient function, and avoiding unwarranted side effects from medication.

### Pain Assessment Instruments

Numerous pain scales exist for the assessment and self-reporting of pain. The visual analog scale (VAS) was developed in the 1970s as a generic pain measure. The VAS is a 10-centimeter line, either vertical or horizontal, with "no pain" at 0 on one side and "worst imaginable pain" at 10 on the other side. It is self-completed by patients with a ruler, and the score is determined by the distance measured between the no-pain anchor and the patients' mark (Hawker, Mian, Kendzerska, & French, 2011). The VAS cannot be administered via telephone or verbally. Patients with cognitive impairment and those with motor skill dysfunction may have difficulty completing this tool independently. However, studies have shown its adequacy in describing pain intensity in patients with somatic pain (Hawker et al., 2011).

The NRS is simpler in scoring than the VAS. The NRS is predominantly used in adults and can be performed verbally and in writing. Various versions exist, but the 11-item NRS is most commonly used (Hawker et al., 2011). A score of 0 represents no pain, and 10 represents “pain as bad as you can imagine.” Many patients prefer the NRS because of its ease of completion. However, one study (Hawker et al., 2011) demonstrated that patients with chronic back pain found the scale to be “inadequate in capturing the complexity of the pain experience or improvements due to symptom fluctuations” (p. S242). The NRS has been the most commonly used pain rating scale since 2000, when the Joint Commission on Accreditation of Health Organizations set new standards implementing pain as the fifth vital sign (Dijk, Kappen, Schuurmans, & Wijck, 2015).

The Revised Iowa Pain Thermometer (IPT-R), an 11-point pain assessment tool, was developed to align with the NRS. The IPT-R has a high level of reliability and validity and can be easily correlated to most healthcare facility standards (Ware et al., 2015). The tool is easily understood by a diverse population, particularly older adults, because it uses a graphic pain thermometer with the NRS and a verbal descriptor scale (Ware et al., 2015).

Pain assessment tools also use objects, such as faces or thermometers, to help patients assess their level of pain. The Wong-Baker Faces Pain Rating Scale is used most often in the pediatric population as young as 3 years old, but it also can extend to the older adult population (Pasero & McCaffery, 2011). The scale was created by asking school-aged children to draw faces that illustrate when they felt “no hurt,” “hurt,” and “the worst hurt you could imagine.” The Faces Pain Scale, a revised version of the Wong-Baker Faces Pain Rating Scale, uses seven different facial expressions to scale feelings of pain in adults (Dogan, Ay, Evcik, Kurtais, & Gökmen Oztuna, 2012).

The Critical Care Pain Observation Tool (CPOT) and Behavioral Pain Scale (BPS) are used in critical care settings to assess pain in patients who may not be able to fully self-report pain. The BPS scores three behavioral items (facial expression, movement, and ventilator adherence), and the CPOT scores these items plus muscle tension. The CPOT also allows scoring of vocalization for non-intubated patients, allowing applicability to a broader patient population. Both tools demonstrate high reliability and validity. The CPOT may better predict pain during procedures or activity, but the difference between the BPS and CPOT are not statistically significant and may require more study (Rijkenberg, Stilma, Bosman, van der Meer, & van der Voort, 2017). Neither the CPOT nor BPS is able to discriminate reliably between agitation and pain in delirious or sedated patients (Rijkenberg et al., 2017).

The Defense and Veterans Pain Rating Scale (DVPRS) (<https://bit.ly/2JbpR4n>) was designed by the Army Pain Management Task Force to assess pain intensity and interference in military and veteran populations. The pain intensity scale uses an NRS with visual cues, color coding, pictorial facial expressions, and

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**“The medical language for pain description does not always correlate with the patient description.”**

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verbal descriptors to improve interpretation of incremental pain intensity levels. DVPRS supplemental questions (<https://bit.ly/2AnB92t>) assess perceived interference of pain with general activity, sleep, mood, and stress (Buchenmaier et al., 2013).

Pain assessment issues exist in current practice because there is no common language for pain and many different assessment tools may be used. Individual patients communicate their pain in dissimilar ways. The medical language for pain description does not always correlate with the patient description. Additional barriers to pain communication may include the fact that classifying pain type can be challenging even for healthcare providers and even more so for individual patients. Pain intensity, pain-related disability, pain duration, and pain effect define different aspects of the pain experience, which can add to confusion.

The DVPRS answers some of these issues. The DVPRS has a similar design to other common pain scales and seeks to enhance the NRS, visual cues, and word descriptor rating scales. The DVPRS differs from other pain assessment tools by incorporating several tools into one user-friendly tool. In addition to facial descriptors and number selection that many patients are familiar with, the DVPRS uses enhanced functional word descriptors at each pain level and traffic light color-coded bars to delineate levels of pain. In addition, the design of the DVPRS helps create a dialogue between patients and providers regarding their pain and its impact on function and state of mind. The DVPRS addresses the need for standard language and communication about pain and how it affects a person from a holistic perspective. The DVPRS supplemental questions on sleep, mood, and level of stress also help quantify the impact of pain and pain-related clinical outcomes (Nassif, Hull, Holliday, Sullivan, & Sandbrink, 2015).

The DVPRS incorporates multidimensional measures of pain interference on daily function, and this makes it effective in monitoring chronic pain (Nassif et al., 2015). The scale encourages patients to explore limitations that pain imposes on activities of daily living and well-being. It serves to educate patients and professionals on a common pain language that is easily understood by patients and healthcare providers.

The tool individualizes pain rating to more than just a single number.

Disadvantages of the DVPRS include the fact that, at this time, its use has been limited to cognitively intact adult patients. Studies on the DVPRS thus far have been focused on military and veteran populations. The combinations of scales and color coding may seem busy or unclear to some patients. The use of the DVPRS requires culture change, which takes time, resources, and financial support from stakeholders. The change to the use of the DVPRS requires intensive education to the multiple disciplines who currently assess patient pain. Current documentation systems designed to accommodate the NRS must be redesigned to accommodate the use of the DVPRS.

### Literature Review

The PubMed, CINAHL®, and Cochrane databases were queried, without exclusive dates, using the following keywords: *Defense and Veterans Pain Rating Scale* or *DVPRS* and *pain scale* or *pain assessment*. The query retrieved 40 articles. After accounting for applicability and duplicates, the authors identified five articles that were relevant to address the validity and efficacy of the DVPRS instrument; three articles were case-controlled studies, one was a review of the development of the tool, and one was an editorial. A seminal study of the DVPRS demonstrated acceptable reliability and validity in a convenience sample of 350 active-duty or retired military service members (Buchenmaier et al., 2013). The tool was validated in its entirety, including the numeric scale, faces scale, traffic light scale, word descriptors, and supplemental items. The word descriptors and supplemental items were subjected to literacy and comprehension tests and were placed from an eighth- to ninth-grade reading level. The authors concluded that the DVPRS tool offered an instrument to standardize pain assessment practices throughout military and veteran healthcare settings and ultimately improved screening and detection of pain-related issues. The authors also noted that the word descriptors may not apply to emergency trauma or low-literacy populations.

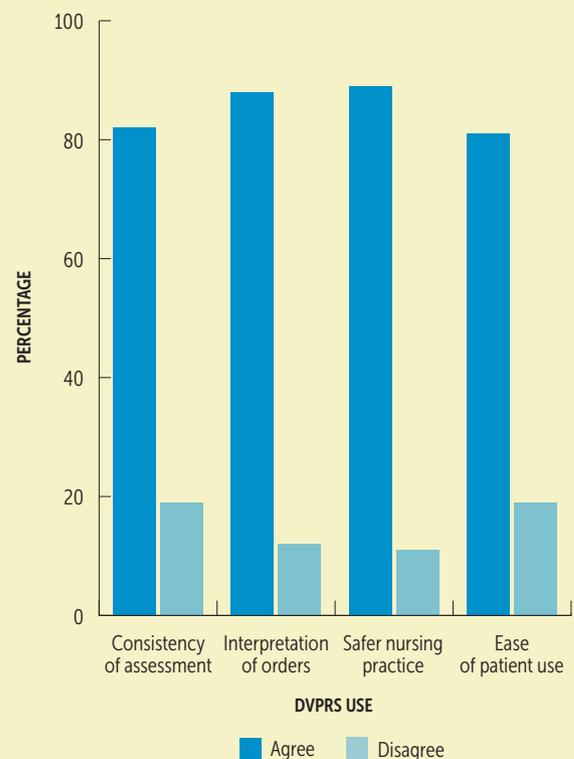
Follow-up studies tested and validated the DVPRS tool exclusively in the outpatient Veterans Affairs population (Nassif et al., 2015). The current study compared concurrent validity of the DVPRS tool to other validated tools. In one sample population, pain interference, pain disability, and quality of life were studied in 204 participants, comparing the supplemental questions in the DVPRS with five other known validated tools. The authors determined that the supplemental questions correlated significantly with the other validated measurements. In the second sample population, pain intensity and supplemental questions were investigated in 13 participants. The DVPRS was administered in conjunction with four other validated tools, and strong correlation was discovered.

Psychometric testing was performed on the revised DVPRS 2.0 in 307 veterans or active-duty members who were

experiencing pain (Polomano et al., 2016). The revisions were made because of copyright restrictions on the original Face Pain Rating Scale; therefore, the DVPRS was revised with a new set of facial representations. The authors concluded that the redesigned tool was reliable and valid in measuring pain and related outcomes. In addition, the authors found that a majority of the patients (219 of 309, 71%) favored the DVPRS 2.0 and that it was superior to other pain scales. Alternatively, the authors also determined that some older adults expressed difficulty understanding DVPRS components (Polomano et al., 2016). The authors recognized that future research must test the DVPRS tool with special populations, including patients with cognitive impairment.

A few rigorous studies (Buchenmaier et al., 2013; Nassif et al., 2015; Polomano et al., 2016) provide efficacy and validity of DVPRS use in veteran and active-duty patient populations. However, no studies have established DVPRS applicability in other patient populations. Therefore, the current study intended to build the evidence to use the DVPRS in the oncology population.

**FIGURE 1.** RESULTS OF THE NURSE SATISFACTION SURVEY ON THE DEFENSE AND VETERANS PAIN RATING SCALE (DVPRS) (N = 64)



## DVPRS in Oncology Clinical Practice

In spring 2017, an evaluation project by the authors began, focusing on the DVPRS instrument in the care of patients with cancer. The purpose of this project was threefold: to improve communication and consistency among patients, nurses, and providers regarding patient pain intensity; to decrease confusion for nurses and providers in the treatment of pain of different intensity (mild, moderate, or severe); and to assess patients' functional status and pain intensity.

### Methods

The methodology for this project began with the evidence-based practice literature review that revealed the DVPRS as an option that may meet all of the previously mentioned criteria. A decision was made among nursing leadership and with physician support to implement a full trial of the DVPRS across the entire campus of the Arthur G. James Cancer Hospital and Richard J. Solove Research Institute in Columbus, Ohio, both inpatient and ambulatory, by May 2017.

Educational support was planned for all disciplines that assess pain throughout the institution, including nurses, physicians, nurse practitioners, physician's assistants, physical therapists, occupational therapists, social workers, clinical nurse specialists, administrative nursing supervisors, educators, managers, and directors, based on their level of participation in pain assessment. A brief 10-minute slideshow with recorded voiceover

was distributed to introduce the DVPRS, the benefits of its use, and the reason for changing the pain assessment. A link to the DVPRS video supplied by the Department of Defense also was distributed. After this preliminary work, nurses and practitioners attended separate face-to-face interactive sessions in which they could apply the DVPRS to patient scenarios and practice using it.

Systems changes that were incorporated included a total revision of the organizational pain policy; lamination and distribution of DVPRS cards to all staff, all inpatient rooms, and all clinics; and revision of several organizational flowsheets and patient education handouts that had previously incorporated other pain assessment scales. Since the initial implementation, the DVPRS has been integrated into the electronic health record (EHR). When documenting, nurses now select the pain assessment scale that is most appropriate for use with their patient, including the DVPRS for cognitively intact adults. The other pain assessment tools available in the EHR include the Pain Assessment in Advanced Dementia, CPOT, and Faces Pain Rating Scale. Nurses then use the DVPRS in the EHR to record patients' pain intensity.

### Results

Evaluation of the implementation of the DVPRS instrument for cognitively intact adults was based on chart audits and satisfaction surveys. Chart audits determined pain medication administration consistency. Nurses and patients completed satisfaction surveys, relaying experience using the DVPRS. Chart audits indicated that pain medication administration consistency of practice among nurses increased by 38% after implementation of the DVPRS. Previous practice demonstrated that nurses interpreted orders for pain medication differently, causing patients to receive different doses of medication for the severity of their pain. With the implementation of the DVPRS, it became clear to nurses, practitioners, and patients that mild pain was reflected in ratings of 1–4, moderate pain was 5 and 6, and severe pain was an intensity rating of 7 or greater.

DVPRS nurse satisfaction surveys were sent out to five representative units, reflecting practice in inpatient and ambulatory care, medical and surgical practice, and general units versus intensive care units. A response rate of 32% of nurses from the representative units was obtained. Figure 1 shows the results of nurse evaluation of the DVPRS in terms of consistency of pain assessment, interpretation of pain medication orders, safer nursing practice, and ease of patient use. Overall, 78% (n = 50) of nurses completing the survey preferred the DVPRS over any other pain assessment tool they had previously used.

Patient satisfaction with the DVPRS was measured with a convenience sample from available inpatient and ambulatory patients currently experiencing pain who were willing to complete a survey rating the tool. Table 1 shows the diagnoses of the 144 patients (60% outpatient, n = 86; 40% inpatient, n = 58) who completed the survey. Patients' ages ranged from 25–78

**TABLE 1.**  
PATIENT DIAGNOSES (N = 144)

DIAGNOSIS	n	%
Leukemia	59	42
Thoracic cancer	26	18
Brain cancer	13	9
Sickle cell disease	10	7
Blood and marrow transplantation	5	4
Multiple myeloma	5	4
Kidney cancer	5	4
Head and neck cancer	5	4
Aplastic anemia	4	2
Gastrointestinal cancer	4	2
Thyroid cancer	4	2
Bladder cancer	4	2

years; 56% were men (n = 80), and 44% were women (n = 64). The survey asked participants to rate three key statements on a Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Survey participants rated all key statements as agree to strongly agree.

## Discussion

Use of the NRS has been the mainstay for pain assessment. Without clear definitions of each rating, this type of scale can be abstract and confusing for patients and nurses. To provide a more comprehensive assessment of pain and patients' pain management goals, Compton and Chang (2017) recommended including functional status in the assessment instrument.

The DVPRS met the outlined objectives for a new tool, which included improved communication and consistency among patients, nurses, and providers regarding pain intensity; clarity around the definitions of different pain intensities; and functional status. The literature supported positive outcomes with use of the DVPRS but only within active-duty and veteran populations. Although a number of patients with cancer fit into those categories, nothing specific to patients with cancer was found in the review. Based on the evidence, the authors chose to implement practice change with use of the DVPRS in the adult, cognitively intact oncology population, with the hopes of duplicating previous results and adding to the body of literature.

## Limitations

Although 78% (n = 50) of nurses completing the DVPRS satisfaction survey preferred the DVPRS, not all nurses received the satisfaction survey. A representative selection of participants received the survey, with a 38% completion rate. Patient satisfaction with the DVPRS was measured with a convenience sample of 144 patients currently experiencing pain who were willing to complete the survey. Demographic data showed that a variety of cancers were represented; however, an inordinately large number of participants were patients with brain and lung cancer and leukemia because of the clinics that were chosen. Therefore, a correlation between cancer type and outcomes could not clearly be made.

Although the authors have found the use of the DVPRS to be an improvement for patients and nurses, this project had some weaknesses. It was completed in just one institution in only a few of the disease-specific clinics. A small number of satisfaction surveys were distributed, with only a 38% completion rate among those who did receive the survey. This may make generalization to all nurses difficult. The number of patients completing the survey was more than 100, but still a relatively small number compared to the total number of patients who experience pain throughout their cancer trajectory. Further investigation surrounding the use of the DVPRS in different patient populations is warranted. The larger institution's plan is to roll this out to all areas where

## IMPLICATIONS FOR PRACTICE

- Ensure thorough, consistent pain assessment and reassessment, because it is critical to guide and evaluate interventions designed to improve pain.
- Focus the goal of pain assessment on the provision of interventions to assist in making the pain tolerable, so as to continue or increase patient function, while avoiding unwarranted side effects from medication.
- Consider using the Defense and Veterans Pain Rating Scale, a multifaceted pain assessment tool that includes self-evaluation of a patient's functional status; it is preferred by nurses and patients for optimal pain assessment in patients with cancer.

patients are assessed for pain and pain control. This will allow for a richer collection of data to support any further needs.

## Implications for Nursing

The DVPRS is a pain assessment instrument that measures pain intensity and patient function. Compared to other pain assessment instruments, the DVPRS provides a more comprehensive pain assessment. Based on satisfaction surveys, nurses and patients responded positively about using the DVPRS to assess pain intensity and patient function.

## Conclusion

In a clinical oncology practice setting, implementation of the DVPRS as a pain assessment instrument improved communication among providers and patients and consistency of assessment when treating pain intensity. Nurse and patient satisfaction survey results were positive about using the DVPRS to assess patients' functional status and pain intensity.

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