Clarifying the Intent of Joint Commission Pain Assessment Standards

Relieving pain is one of the central missions of health care. The field of medicine benefits from an increasing set of evidence-based treatments for pain, including nonpharmacologic modalities (such as acupuncture, chiropractic therapy, osteopathic manipulative treatment, massage therapy, physical therapy, relaxation therapy, and cognitive behavioral therapy) and pharmacologic modalities (such as nonopioid, opioid, and adjuvant analgesics). At the same time, this wide array of treatment options can make it more difficult to decide on the optimal treatment regimen for an individual patient. Appropriate treatment may vary depending upon the disease process, the prognosis, the patient's overall physical and mental health, and the patient's preferences. Therefore, a comprehensive assessment of the patient's pain and attitudes toward treatment is a critical first step towards controlling the pain.

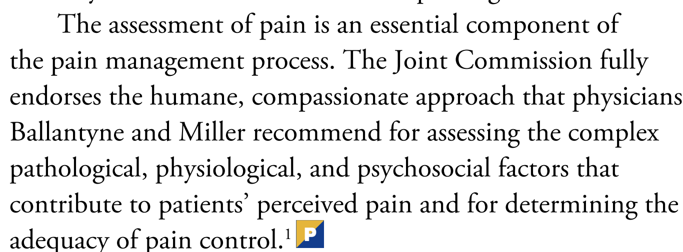
While The Joint Commission has standards related to pain management in multiple accreditation and certification programs, the goal of this article is to debunk some common misconceptions about the intent of the standards specific to pain *assessment*.

A fitting example is the simply-stated Joint Commission pain assessment standard, Provision of Care, Treatment, and Services (PC) Standard PC.01.02.07 for hospitals: "The hospital assesses and manages the patient's pain." Pain assessment is then addressed further in three of this standard's elements of performance (EP):

- EP 1—The hospital conducts a *comprehensive* [emphasis added] pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition.
- EP 2—The hospital uses methods to assess pain that are *consistent with the patient's age, condition, and ability to understand* [emphasis added].
- EP 3—The hospital reassesses and responds to the patient's pain, *based on its reassessment criteria* [emphasis added].

Joint Commission standards do not require the use of any particular treatment modality, whether nonpharmacologic or pharmacologic. The Joint Commission also does not specify any of the following:

- **How the assessment should be done.** Joint Commission surveyors evaluate compliance with the organization's own policies. As stated in the introduction to Standard PC.01.02.01, "Assessment activities may vary between settings, *as defined by the hospital's leaders* [emphasis added]."
- **Whether numerical pain scales should be used.** A recent article by Ballantyne and Sullivan criticized the use of numerical intensity scales as the sole tool for assessing patients with chronic pain.[1] The Joint Commission believes this criticism also applies to the assessment of acute pain. Numerical pain scales can be appropriate and helpful as part of the initial comprehensive assessment, but they are not required by Joint Commission standards and are usually inadequate on their own. Indeed, the fact that some patients have difficulty assigning scores to their pain (as implied in Standard PC.01.02.07, EP 2) could mean that qualitative assessments of severity (such as mild, moderate, or severe) may work better.



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- **When reassessment should occur.** The timing of reassessment to determine the adequacy of the pain treatment plan should be specified by the organization.

The Joint Commission does *not* specify that the goal of treatment is complete elimination of pain and does *not* require organizations to set numerical treatment goals. The goal of pain treatment is to reduce discomfort to a desired, achievable level as determined by the patient. Oftentimes patients will tolerate a higher level of pain in exchange for being more alert and able to interact with loved ones. In addition, as Ballantyne and Sullivan point out, the level of discomfort is also determined by the patient's anxiety.[1] Because pain may evoke fear or depression, simply increasing pharmacological therapy will not only be ineffective but also could pose significant risk.

The assessment of pain is an essential component of the pain management process. The Joint Commission fully endorses the humane, compassionate approach that physicians Ballantyne and Miller recommend for assessing the complex pathological, physiological, and psychosocial factors that contribute to patients' perceived pain and for determining the adequacy of pain control.[1]

Reference

1. Ballantyne JC, Sullivan MD. Intensity of chronic pain—The wrong metric? *N Engl J Med.* 2015 Nov 26;373(22):2098–2099.

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