

Pain Assessment and Management in the Older Adult with Cognitive and/or Language Impairment

Quick Links:

- [Faces Pain Scale Revised© \(FACES-R©\)](#)
- [Numeric Rating Scale \(NRS\)](#)
- [Verbal Descriptor Scale \(VDS\)](#)
- [Pain in Advanced Dementia \(PAINAD\)](#)
- [Discomfort/Behavioral Indicators of Pain](#)
- [Analgesic Trial](#)
- [Pain Monitoring Standards](#)
- [Documentation](#)
- [Pain Assessment & Management Algorithm](#)
- [Hierarchy of Pain Assessment Techniques](#)

Site Applicability

All VCH Acute Care Sites

Practice Level

Basic skill for the following professions within their scope of practice and according to the team member's competencies and clinical decision making ability:

- RN, NP, LPN, RPN
- Occupational Therapist (OT)
- Social Worker (SW)
- Speech Language Pathologist (SLP)
- Recreation Therapist (Rec T)
- Psychologist
- Dietitian (RD)
- Physiotherapist (PT)
- Pharmacist
- Spiritual Care
- Respiratory Therapist (RT)

Policy Statement

- **Within 48 hours of admission**, all adults with cognitive and/or language impairment will have a pain assessment completed and a plan of care developed and implemented.
- All patients receiving an **Analgesic Trial** will be monitored **Q1H (sedation level & respiratory rate) for 12 hours, then Q2H for 12 hours, then Q4H & PRN**.
- Interdisciplinary team members are professionally and ethically obligated to advocate for optimal pain assessment and management for all older patients affected by cognitive and/or language impairment.
- All older patients and their family/caregiver will be involved in pain assessment/evaluation and their goals for comfort/function will be incorporated into the plan of care.

Need to Know

- Pain is not a normal part of aging and there is no evidence that aging is associated with a decreased sensitivity to pain.
 - Patients with a cognitive and/or language impairment may be unable to:
 - a) interpret noxious sensations as painful,
 - b) recall their pain, and
 - c) communicate the experience of both pain and side-effects of medications to their health care providers.
 - The consequences of untreated/undertreated pain include new onset delirium, aggression, delayed wound healing, decreased appetite and weight loss, prolonged hospitalization, and negatively influence sleep, mood, activity patterns, activities of daily living (ADL), and quality of life.
- **Prevalence of Pain:** Studies in adults over age 65 report that:
 - Pain is a number one complaint in older adults.
 - One in five older adults takes daily pain medications.
 - 25 to 50% community dwellers have persistent pain.
 - 45 to 80% facility residents report untreated pain.

Note: This is a **controlled** document for VCH internal use. Any documents appearing in paper form should always be checked against the electronic version prior to use. The electronic version is always the current version.

- Pain, that affects physical, functional, emotional and cognitive abilities, as well as the spiritual and/or quality of life experiences of older patients, is a significant clinical and ethical concern for all health care professionals

Definitions: see [Appendix A](#)

Practice Guideline

Pain Monitoring Standards

All patients who have cognitive and/or language impairment will have an:

1. **Assessment for pain:**
 - On admission, and
 - Every shift, and
 - Whenever there is change in behavior/condition, and
 - Q1H when pain indicators suggest that the goals for comfort/function have not been met.
 - **During an Analgesic Trial: Q1H (sedation level & respiratory rate) X 12 hours, then Q2H X 12 hours, then Q4H** (see [Appendix I](#))
2. **Plan of Care:**

A plan of care will be developed and implemented within **48 hours** of admission. This plan will be reviewed every shift (minimum) and whenever the patient's condition changes.

A. Assess for Pain using the Hierarchy of Pain Assessment Techniques:

(Adapted from: Herr et al., 2006; Pasero & McCaffery, 2011)

1. **Focus on the Present Pain/Elicit the Patient's Self-Report:**
 - Patients with mild to moderate cognitive impairment and/or declining verbal abilities can respond to simple yes/no questions (i.e. "Knee aches?", "Toes burn?") or to a numeric rating (NRS – see [Appendix B](#)) or visual descriptor scale (VDS – see [Appendix C](#)).
 - Ask the patient about the present pain rather than the history of pain. If the patient cannot understand the word 'pain', try other words that describe pain such as ache, burn, hurt or discomfort.
 - When patients deny pain, use statements rather than questions and use similar descriptive words such as aching, burning, hurting or discomfort.
2. **Involve the Family/Caregiver:**

Ask family or caregivers whether the patient's current behavior (e.g., calling out, restlessness) is typical or different from their usual behavior. Family members are likely to be caregivers and their familiarity with the patient can assist in identifying changes that may be discomfort/behavioral indicators of pain.
3. **Identify Pain History:**

Pain history may be identified with patients (as appropriate), the family/caregiver and a chart review. Identify as appropriate:

 - Past pain history (i.e., trauma/falls, coping, comfort measures, treatment effectiveness; impact of pain on sleep, mood, behavior, ADLs).
 - Location, quality, aggravating/relieving factors
 - Estimated intensity of pain (see [Appendix A](#))
 - Impact of current illness on pain
 - Physiological indicators
 - Pain experiences (i.e, meaning of pain) & distress caused by pain.

4. **Identify Sources of Pain/Discomfort:**

Identify potential sources of acute/persistent/chronic/neuropathic pain such as GI reflux, metastatic cancer, fractures, recent surgery, arthritis, neuropathy and leg ulcers (Sources of Pain - [Appendix B](#)). Recent falls, fractures and other acute pain-related conditions (i.e., UTI, oral ulcers and constipation) may be triggers for aggression. Pain may be caused by common care procedures such as wound care, turning, transfers, drawing blood and BP monitoring.

a. **Nociceptive Pain:** see [Definitions](#)

b. **Neuropathic Pain:** see [Definitions](#)

5. **Use Pain Screening Tools in Patients with Mild to Moderate Cognitive/Language Impairment:**

Combining self-report and physical assessment provide the best source of data for verbal patients. Select a tool that is appropriate to the patient's abilities. If the patient is unable to understand one tool, try again with another. The three tools that provide a patient's estimate of pain intensity are:

- [FACES-Revised© \(FPS-R©\)](#) or
- [Numeric Rating Scale \(NRS\)](#) or
- [Verbal Descriptor Scale \(VDS\)](#)

6. **Observe Discomfort/Behavioral Indicators in Patients with Advanced Cognitive/Language Impairment:**

- In addition to physical assessment, observe verbal/nonverbal discomfort or behavioral indicators and changes in functional ability that suggests pain ([Appendix F](#)). The three main discomfort/behavioral indicators are:
 - Facial expressions, verbalizations/vocalizations and body movements.
 - Additional indicators include changes in social interactions, changes in routines/activities, and mental status change ([Appendix F](#)).
 - Pain-related behaviors should be observed during activity and at rest. If pain-related behaviors are not present during movement and the patient continues to exhibit behaviors that suggest pain, assess for basic needs such as toileting, thirst, hunger and constipation.
- a) **Behavioral Observation Tool: Pain Assessment in Advanced Dementia (PAINAD)**
- Use PAINAD ([Appendix G](#)) to identify the presence of pain and to evaluate the effectiveness of treatment in patients who are cognitively and/or language impaired.
 - PAINAD identifies five behavioral indicators of pain: breathing, negative vocalization, facial expression, body language, and consolability. For definitions and scoring, see [Appendix G](#).

7. **Recommend an Analgesic Trial ([Appendix H](#)):**

- If pain is suspected, collaborate with the physician/nurse practitioner (NP) to initiate an Analgesic Trial to evaluate the presence of pain.
- Based on the estimated intensity of pain (see [Appendix A](#)), recommend a regularly scheduled non-opioid for mild to moderate pain plus an opioid for more severe pain.
- Ensure that the patient receives PRN, or breakthrough, analgesic prior to procedures known to cause pain such as wound care, turning, transferring and mobilizing. The goal is to prevent acute episodes of pain/discomfort and to ensure a consistent level of analgesia.
- Set comfort/function goals (see [Appendix A](#)) for pain relief with the patient/family/caregiver.
- If the analgesics appear to reduce discomfort/behavioral indicators and relieve pain, **it may be assumed that pain was the cause and the analgesic should be continued.**
- Follow the World Health Organization Analgesic Ladder (WHO) step wise approach to increasing classifications of medications ([Appendix K](#)).

8. **Analgesic Assessment and Monitoring Standards** ([Appendix I](#)):

All patients started on an opioid/non-opioid **Analgesic Trial** will be assessed according to the **Pain Monitoring Standards**:

Pain Monitoring Standards	
1. The patient is to be assessed Q1H (sedation level and respiratory rate) X 12 hours, then Q2H X 12 hours, then Q4H/as per unit routine & PRN until:	<ul style="list-style-type: none"> Self-report, pain scale(s) and/or discomfort/behavior(s) indicate consistent pain relief Sedation level/respiratory rate, in response to the analgesic trial, is within normal limits for the patient. Anticipated side-effects of medications are minimized or absent.
2. The effectiveness of analgesia is evaluated by:	<ul style="list-style-type: none"> NonVerbal Behavior Indicators The discomfort/behavioral indicators, PAINAD score and/or the family/caregiver report indicate relief of pain. Verbal Indicators The patient verbally expresses that: <ul style="list-style-type: none"> their goals for comfort/function are attained, and he/she is satisfied with the pain management plan and/or FACES-R®, NRS or VDS scores consistently demonstrates lower scores of pain intensity
3. When Pain and Behavior is NOT controlled:	<ul style="list-style-type: none"> Assess self-report, pain scale, discomfort/behavior(s) and goals for comfort/function Q1H in addition to sedation level and respiratory rate. If the behavior(s) persists and/or escalates, continue non-opioid with/without opioid analgesics plus the addition of PRNs as ordered. If the pain-related behaviors do not decrease or the goals for comfort/function are not reached within 2 (two) hours, inform the Physician/NP and the interdisciplinary team. Request a referral to a pain/geriatric specialist where appropriate. See Appendix H.
4. Documentation:	<ul style="list-style-type: none"> On appropriate interdisciplinary notes, document the pain-related/discomfort behaviors, triggers, pattern of escalation, and success/nonsuccess of pharmacologic/non-pharmacologic approaches.
NOTE: <ul style="list-style-type: none"> If the analgesic trial appears ineffective, do not assume that pain is not present. The dose may need to be titrated upwards before seeing an improvement in pain/discomfort indicators. 	

a. **Pain Assessment & Management Algorithm** – See [Appendix J](#)

9. Develop/Implement a Plan of Care:

Within 48 hours of admission, use the patient's self-report, observation/pain behavior tool and/or the family/caregiver report to develop a plan of care in collaboration with the family/caregiver/interdisciplinary team. The plan should be consistent with the patient and family/caregiver goals for comfort/function and include pharmacologic and non-pharmacologic interventions.

a. Non-pharmacologic interventions that can be attempted with/without analgesics are:

- Develop a positioning schedule
- Assess the need for therapeutic mattress and seating
- Provide assistive devices to maintain participation in ADLs
- Promote adequate periods of rest during the day and sleep at night
- Identify strategies to promote participation in activities despite the presence of pain such as:
 - A daily routine
 - Graded activity (completing part of task within tolerance)
 - Review timing and pacing of activities with rest breaks
- Provide an individualized exercise program
- Offer reassurance and acknowledgement of suffering, as appropriate
- Provide massage, as appropriate
- Provide cold articles to promote comfort (i.e. cold cloth)
- Provide the patient/family with information about pain and what to expect
- Utilize strategies that patient used successfully at home to relieve pain
- Offer distraction, relaxation
- Promote conversational and social capabilities
- Encourage reminisce and life review
- Utilize humor, as appropriate
- Provide warm articles to promote comfort (i.e. warm blanket, socks, sweater)
- Promote psychological assessment and treatment, where available
- Enhance spirituality as appropriate

*****For patients with moderate to severe pain, provide pain medications in addition to non-pharmacologic interventions.**

10. Emotional and Spiritual Considerations:

If the patient's symptoms remain after evaluation of the care plan, consider the possibility that a portion of the pain presentation may be related to emotional and/or spiritual suffering.

Just as pain can affect emotional and spiritual experience, emotional and spiritual suffering can present as pain. Therefore, it is important to consider any indicators suggesting a portion of the presenting symptoms may be due to emotional or spiritual suffering. Spiritual care may be an important part of the life of the older patient especially when they are in pain. In the journey with the patient and their family/caregiver, spirituality is expressed in the attitudes, beliefs and practices which affect the patient's ability to cope with and express their pain.

11. When Pain is not Relieved: Advocate!

When the patient's goals for comfort/function are not met by the current care/treatment plan, advocate for the patient using a structured rationale to support changes including:

- Patient's self-report and/or the estimated intensity of pain
- Change in pain scores over past 24 hours
- Amount of regular & breakthrough/24 hours
- Patient/family/caregiver goals for comfort/function
- Effect of unrelieved pain (i.e. emotional, psychological, spiritual suffering)
- Recommendations from the interdisciplinary team, and
- Recommendations for specific changes/referral/follow up

Expected Patient/Family Outcomes

1. The patient verbalizes/demonstrates that the goals for comfort/function are achieved and that he/she is able to participate in activities that contribute to physiological, emotional, spiritual and psychological health, including ADLs as appropriate.
2. The patient's behavioral/discomfort indicators and/or pain scale scores consistently demonstrate increased comfort and functional abilities.
3. The family/caregiver indicates that the patient's pain has been relieved and that he/she appears comfortable.

Patient/Family Education

As indicated, provide the patient and/or family/caregiver with information about:

- their pain, how it is treated and prevention of medication related side-effect
- how a pain behavior tool is used to assess pain in patients with cognitive/language impairment
- how pain scales are used to assess and monitor pain
- how goals for comfort and function are established in the plan of care
- regular and PRN use of medications to reduce pain
- actions that will be taken if the pain score is above the goals for comfort/function
- myths regarding aging and pain
- differences between addiction, tolerance and physical dependence as appropriate, and
- importance of non-pharmacologic approaches in the prevention and relief of pain

Educational Resources for Patients/Families/Caregivers:

Print Health Education Materials: order through [VCH](#)

- Pain in the Older Adult ([FM.800.P35](#))
- Neuropathic Pain ([FM.800.N494](#))
- Pain and Ways to Manage It ([FM.850.M311](#))

Pain BC Society website: [Pain BC](#)

Documentation

On appropriate interdisciplinary notes, document the results of the assessment and care plan including:

1. Ongoing assessments and monitoring including:
 - Discomfort indicator(s)
 - Pain scale used (i.e. self-report/patient/family words, FACES-R®, NRS, VDS, discomfort/behavioral observations)
 - Pain score result
 - Pharmacologic/non-pharmacologic intervention(s)
 - Sedation level/respiratory rate in response to the analgesic trial
2. Factors shaping the experience of pain (i.e., insomnia, mood, appetite, function, spirituality) as appropriate
3. The effectiveness of the pain management plan and the patient/family/caregiver satisfaction with pharmacologic/non-pharmacologic interventions

Related Documents

VCH:

- D-00-07-30067: [Basic Pain Assessment & Management of the Older Adult in Residential Care](#)
- VA: P-075: [Pain Assessment and Documentation](#)
- VA: P-070: [Care and Management of the Patient with Chronic Malignant or Non-malignant Pain](#)
- VA: P-153: [Visual Analogues in English, Chinese, Korean, Punjabi, and Vietnamese](#)

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Website Resources:

- [City of Hope: Pain Resource Center](#)
- [Geriatric Pain Resources](#)
- [Hartford Institute for Geriatric Nursing](#)
- [International Association for the Study of Pain](#)
- [Registered Nurses Association of Ontario](#)
- [Canadian Pain Society](#)
- [Pain Assessment and Management](#) (Winnipeg Regional Health Authority)
- [Pain BC](#)

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Date of Approval/Review/Revision

Approved: October 2, 2014

Posted: October 20, 2014

Appendix A: Definition

Definition of Key Terms	
Acute Pain	Acute pain occurs secondary to a time-limited illness such as surgery, medical procedure, or injury/trauma. It is usually associated with an increase in autonomic nervous system signs such as increased BP and tachycardia which may subside when the disease/injury resolves.
Addiction	A chronic, neurobiological disease characterized by impaired control over drug use, compulsive use, craving, and continued use despite harm (<i>American Geriatrics Society, 2009</i>). Rare in older adults treated for pain.
<ul style="list-style-type: none"> Tolerance 	A decrease in the pain relieving effects of opioids or other medications. Patients need more frequent doses or an increased dose to achieve the initial effect of pain relief. Tolerance does not imply addiction. (<i>McCaffery & Pasero, 1999</i>)
<ul style="list-style-type: none"> Physical Dependence 	A physical state in which abruptly stopping an opioid or giving an opioid antagonist (i.e. Narcan) results in withdrawal. Physical dependence does not imply addiction. (<i>McCaffery & Pasero, 1999</i>)
Analgesics	Analgesics are medications used to relieve pain.
<ul style="list-style-type: none"> Opioids 	Opioids act in the central nervous system and alters the patient's perception.
<ul style="list-style-type: none"> Non-Opioids 	Non-opioid , analgesics such as acetaminophen, act on the site of the pain, do not produce tolerance, and do not alter the patient's perception.
<ul style="list-style-type: none"> Adjuvants 	Adjuvant analgesics such as anticonvulsants and some antidepressants relieve pain through other mechanisms. (<i>McCaffery & Pasero, 1999</i>)
Analgesic Trial	An analgesic trial is used to evaluate the presence of pain. The amount of analgesic is based on the estimated intensity of pain (see Appendix A), analgesic history and pain assessment.
Atypical Pain Presentation	Pain may present atypically or outside the traditional signs, symptoms and anticipated pattern of pain. An atypical presentation of pain may be vague or altered symptoms. For example, an older patient with an acute abdomen may present without any symptoms or with mild discomfort and constipation.
Cognitive Impairment	Cognitive refers to the mental processes characterized by knowing, thinking, learning, remembering & judgment. Impairment of cognition may result in an inability to understand the concepts of pain, pain intensity and/or to respond to questions about pain.
Comfort/Function Goals	Goals are set with patients/families/caregivers to determine how much pain can exist without interfering with function and quality of life. Goals are appropriate for both acute and chronic/persistent pain. Note: Patients should be assured that pain existing above the goals will result in further interventions (<i>Pasero & McCaffery, 2011</i>)
Discomfort Indicator(s)	Discomfort/behavioral indicators include verbal/nonverbal behaviors and/or changes in functional status that suggest pain (Appendix F).
Estimated Intensity of Pain	Based on the assessment of discomfort/ behavioral indicators (Appendix F), the estimated <i>intensity of pain</i> is the likelihood that pain is at a certain level. Estimated intensity may be made worse by the number/complexity of variables such as illness, noise, stress, type of pains, location of pain, surroundings, intensity of pain, etc. Note: Accurate pain intensity can only be verbalized by the person experiencing pain. In cognitively impaired/nonverbal patients, pain intensity can only be estimated.

Note: This is a **controlled** document for VCH internal use. Any documents appearing in paper form should always be checked against the electronic version prior to use. The electronic version is always the current version.

Definition of Key Terms (cont'd)	
Non-verbal	To be verbal is to have the ability to express oneself and communicate in words/writing. Cognitive impairment (i.e., dementia) and illness (i.e., stroke) may limit the patient's ability to express him/her self verbally and/or in writing (see cognitive impairment). Note: The inability to communicate verbally does not exclude the possibility that an individual is experiencing pain and needs assessment and treatment. (<i>American Geriatrics Society, 2009</i>)
Pain	<ul style="list-style-type: none"> Pain is whatever the experiencing person says it is, existing whenever the experiencing person say it does (<i>McCaffrey & Pasero, 1999</i>) An individual's memories, expectations, and emotions modify the experience of pain (<i>American Geriatric Society, 2009</i>) An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (<i>IASP, 1986</i>)
• Nociceptive Pain	Pain produced in response to injury and/or inflammation that alerts an individual to impending tissue damage. Usually described as dull or aching. Injury and/or inflammation that is produced secondary to tissue damage and associated with both acute (i.e, angina) and chronic conditions (i.e. scoliosis). Patients should be assessed upon admission and every shift for pain that interferes with ADLs & quality of life.
• Neuropathic Pain	Pain produced by damage to or dysfunction of neurons in the peripheral or central nervous system (<i>McCaffery & Pasero, 1999</i>). Usually described as sharp, burning, coldness, or tingling, electric shocks, shooting or burning pain or a feeling of coldness in the affected area. Patients with spinal cord injury, stroke, diabetes, herpes zoster or peripheral vascular disease may have neuropathy and should be assessed upon admission and reassessed every shift.
• Persistent/Chronic Pain	Pain that continues for a prolonged period of time and may or may not be associated with a well-defined disease process. (<i>American Geriatric Society, 2009</i>)
• Breakthrough Pain	A transitory flare of pain of moderate to severe intensity that usually occurs with/without movement and with procedures (<i>Adapted from: WRHA, 2012</i>).
Non-Pharmacologic or Non-Medication Therapy	Non-pharmacologic treatments include interventions such as emotional support, relaxation, warm blankets or music to minimize the effects of pain.
Start low, go slow	Start low; go slow is an approach to medication management in which analgesics are started at the lowest prescribed dose and gradually titrated upwards while evaluating the patient's response: <ul style="list-style-type: none"> Continue to give PRN or breakthrough medications as needed. Increase the regular dose increased every 24 hours during the analgesic trial based upon the patient's need for PRNs. Slow titration is essential due to a more fragile blood brain barrier in the cognitively impaired and a higher risk for delirium. However, this risk does not out- weigh the benefit of treatment.
World Health Organization (WHO) Analgesic Ladder	An international guide for determining the type of analgesics, the ladder supports geriatric concepts of the estimated intensity of pain and the medication principle of "start low and go slow." See Appendix K

Appendix B: Numeric Rating Scale (NRS)

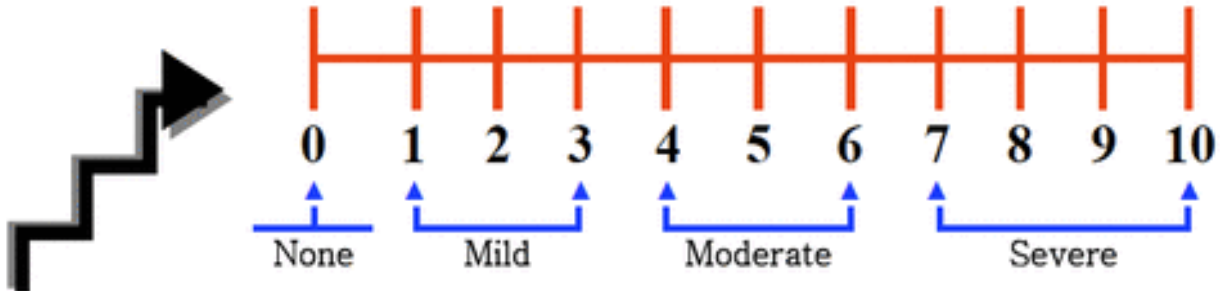
Indications:

NRS is a tool used with adults with mild cognitive impairment who are able to use numbers to rate the *intensity* of their pain.

Instructions:

1. Ask the patient any **one** of the following questions:
 - What number would you rate your pain right now?
 - What number on a 0 to 10 scale would you give your pain when it is the worst that it gets?
 - What number on a 0 to 10 scale would you give your pain when it is the best that it gets?
 - At what number is the pain at an acceptable level for you?
2. When the explanation in #1 above is not sufficient for the patient, try to further explain or conceptualize the NRS in the following manner:

- | | | |
|---------------|---|---|
| 0 | = | No Pain |
| 1 - 3 | = | Mild Pain (nagging, annoying, interfering little with daily activities) |
| 4 - 6 | = | Moderate Pain (interferes with many daily activities) |
| 7 - 10 | = | Severe Pain (disabling; unable to do almost all daily activities) |



3. The interdisciplinary team in collaboration with the patient/family (if appropriate) will determine appropriate interventions according to the acceptable level of pain

Adapted from: Pasero & McCaffery, 2011

Appendix C: Verbal Descriptor Scale (VDS)

Instructions:

The VDS is suitable for articulate patients who can use verbal terms to express the level of their pain.

- Ask the patient to read the scale and either place a mark or point to the phrase that best describes the current intensity of their pain, or
- The team member may read the scale to the patient who can then express their level of pain intensity.

Scoring:

- A response of “No Pain” is given a value of zero.
- A response of the “Worst Possible Pain” is given a value of 10.
- An average score can be determined by adding all the values from each assessment and dividing by the number of assessments.

☀ No Pain

☀ Mild Pain

☀ Moderate Pain

☀ Severe Pain

☀ Very Severe/Extreme Pain

☀ Worst Possible Pain

Adapted from: Herr et al., 2001

Appendix D: Common Diagnoses / Conditions Leading to Pain

Diagnosis/Condition	Signs & Symptoms
Musculoskeletal (40%)	<ul style="list-style-type: none"> Tightness, stiffness, spasm, acute pain
Osteoarthritis (37%)	<ul style="list-style-type: none"> Deep aching pain, joint swelling/pain/ tenderness
Fractures (14%)	<ul style="list-style-type: none"> Severe localized pain, muscle spasm
Neuropathy (11%)	<ul style="list-style-type: none"> Burning, tingling, shock-like stabs; cold/hot; pins & needles
Peripheral vascular disease (8%)	<ul style="list-style-type: none"> Intermittent sharp stabs, burning, stiffness
Cancer (3%)	<ul style="list-style-type: none"> Variable: aching, stabbing; acute/chronic
Headaches (6%)	<ul style="list-style-type: none"> Dull, aching, throbbing, visual disturbance
Generalized Pain (3%)	<ul style="list-style-type: none"> All-over discomfort, aching, sharp stabs
Pleuritic	<ul style="list-style-type: none"> Sharp, localized; ↑ with coughing, moving
GI Reflux	<ul style="list-style-type: none"> Heartburn, regurgitation (sour/bitter taste)
Myocardial Ischemia: acute/ chronic (angina)	<ul style="list-style-type: none"> Tightness, squeezing, indigestion, ill-defined pain
Temporal Arteritis	<ul style="list-style-type: none"> Headache, visual disturbances
Infection: UTI, C. diff, osteomyelitis, wounds	<ul style="list-style-type: none"> Aching, nauseating, piercing sharp stabs, cramping
Oral Disease/Hygiene	<ul style="list-style-type: none"> Refusing to eat/drink; dull/sharp, gnawing

Adapted from: Miaskowski, 1999; Passero & McCaffery, 2011

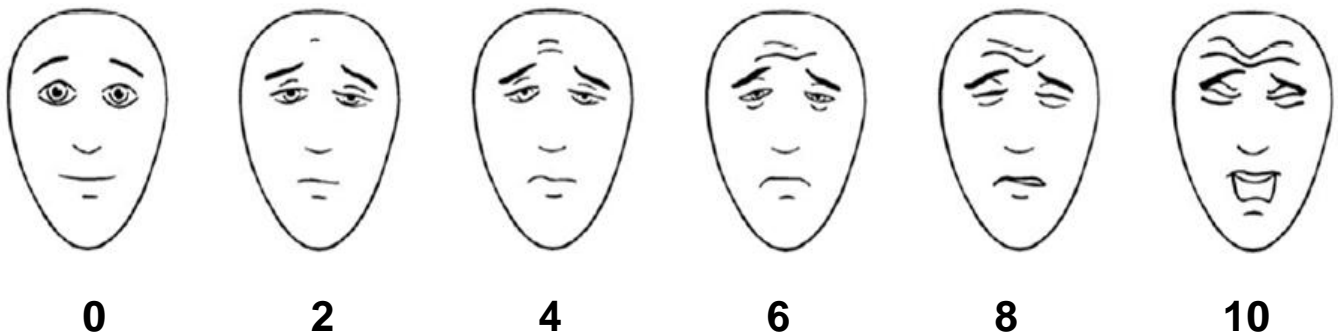
Appendix E: Faces Pain Scale – Revised© (FPS-R©)

Indications:

The Faces Pain Scale is a self-report measure of pain *intensity* for use with older adults with mild to moderate cognitive impairment. This 0 to 10 scale is intended to measure how older patients feel inside, not how their face looks.

Instructions:

1. Say hurt or pain whichever seems right for each older patient.
2. Do not use words like happy and sad (cues emotions rather than pain).
3. Try saying:
 - "These faces show how much something can hurt.
 - This face - *point to face on the left* - shows no pain.
 - The faces show more and more pain - *point to each face from left to right* - up to this one - *point to face on the right* - it shows lots of pain.
 - Point to the face that shows how much you hurt."



Scoring:

- Score the chosen face 0, 2, 4, 6, 8, or 10
 - Count the faces from left to right.
 - 0 = no pain – 10 = maximum amount of pain possible.
4. Comment positively to the patient on how well he/she has done and
 5. State that you will work with them/family/caregiver and the health care team to relieve their pain (if they have pain).
 6. Help the patient/family/caregiver set a goal for their acceptable level of pain.

FPS-R translations

Adapted with permission from: FPS-R©: International Association for the Study of Pain (2001) –

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Appendix F: Discomfort / Behavioral Indicators of Pain

1. Facial Expressions

- Slight frown, sad expression, frightened look
- Grimacing
- Wrinkled forehead, closed or frightened eyes
- Rapid eye blinking
- Any distorted expression

2. Verbalizations, Vocalizations

- Sighing; moaning; groaning
- Grunting; chanting, calling out
- Noisy breathing
- Asking for help
- Verbally abusive

3. Body Movements

- Guarding or abnormally rigid, tense movements
- Fidgeting
- Increased pacing; rocking
- Restricted movement
- Gait or mobility changes

4. Changes in Social Interactions

- Aggressive, combative, resisting care
- Decreased social interactions
- Socially inappropriate, disruptive
- Withdrawn

5. Changes in Routines, Activities

- Refusing food; appetite change
- Bed seeking
- Sleep, rest pattern changes
- Sudden cessation of common routine
- Increased wandering

6. Mental Status Changes

- Crying or tearful
- Increased confusion
- Irritability or easily distressed
- Decreased attention/concentration
- Decreased recall of recent events

Adapted from: American Geriatrics Society, 2002, 2009; Pasero & McCaffery, 2011; Shega et al, 2008

Appendix G: Pain Assessment in Advanced Dementia (PAINAD)

Purpose:

1. PAINAD identifies five behavioral indicators of pain: breathing, negative vocalization, facial expression, body language, and consolability. This assessment may be done with the family/caregiver.

How to Use:

1. Observe for 3 to 5 minutes during activity/with movement.
2. For each of the 5 indicators, select the score (0, 1, 2) that reflects the current behavior. Definitions for each indicator are available on the following pages.
3. Add the score for each indicator to achieve a total score. Total scores range from 0 to 2, with a higher score suggesting more severe pain.
4. After each use, compare the total score to the previous score received. An increased score suggests an increase in pain, while a lower score suggests pain is decreased.
5. The pain score reflects the presence and/or absence of pain. The score is compared against the patient's baseline pain behaviors (when known).
 - **Note:** The pain score cannot be compared to standard pain intensity ratings (i.e, FACES-R, NRS).

Documentation:

- Where applicable, document on the flow sheet.
- On appropriate interdisciplinary notes, document the pain-related/discomfort behaviors, triggers, pain score, pattern of escalation, and success/nonsuccess of pharmacologic/non-pharmacologic approaches

Behavior	0	1	2	Score
Breathing • Independent of vocalization	• Normal	• Occasional labored breathing • Short periods of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative Vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial Expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body Language	• Relaxed	• Tense • Distressed pacing • Fidgeting	• Rigid • Fists clenched • Knees pulled up • Pulling or pushing away • Striking out	
Consolability	• No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
TOTAL SCORE				

Adopted from: Warden et al., 2003

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Appendix G (cont'd): Pain Assessment in Advanced Dementia (PAINAD) - Definitions

Breathing	
Normal breathing	Effortless, quiet, rhythmic (smooth) respirations.
Occasional labored breathing	Episodic bursts of harsh, difficult, or wearing respirations
Short period of hyperventilation	Intervals of rapid, deep breaths lasting a short period of time.
Noisy labored breathing	Negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
Long period of hyperventilation	Excessive rate and depth of respirations lasting a considerable time.
Cheyne-Stokes respirations	Rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).
Negative Vocalization	
None	Speech or vocalization that has a neutral or pleasant quality.
Occasional moan or groan	Mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
Low level speech with a negative or disapproving quality	Muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
Repeated troubled calling out	Phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
Loud moaning or groaning	Mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
Crying	Utterance of emotion accompanied by tears. Sobbing or quiet weeping.
Facial Expression	
Smiling or inexpressive	Upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look
Sad	Unhappy, lonesome, sorrowful, or dejected look. Tearful.
Frightened	Look of fear, alarm, or heightened anxiety. Eyes appear wide open
Frown	Is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear
Facial grimacing	Distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut

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Appendix G (cont'd): Pain Assessment in Advanced Dementia (PAINAD) - Definitions

Body Language	
Relaxed	Calm, restful, mellow appearance. The person seems to be taking it easy.
Tense	Strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
Distressed pacing	Activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
Fidgeting	Restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
Rigid	Stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
Fists clenched	Tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
Knees pulled up	Flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
Pulling or pushing away	Resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
Striking out	Hitting, kicking, grabbing, punching, biting, or other form of personal assault.
Consolability	
No need to console	Sense of well-being. The person appears content.
Distracted or reassured by voice or touch	Disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
Unable to console, distract, or reassure	Inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

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Adapted from: Warden et al., 2003

Appendix H: Analgesic Trial - for Suspected Pain in Adults with Cognitive and/or Language Impairment

A. When to Recommend an Analgesic Trial

- Common diagnoses/conditions likely to cause pain exist (see [Appendix D](#))
- Procedures/ADLs likely to cause pain are scheduled.
- Discomfort/pain behavior(s) continue after attention to basic needs and comfort measures.
- The level or estimated intensity of pain is above the goals for comfort/function.
- The **Hierarchy of Pain Techniques** assessment reveals pain behavior/discomfort indicators.
- Family/caregivers report previous chronic pain and/or behaviors that indicate pain.

B. Step by Step: An Analgesic Trial Outlined

1. Ensure that potential causes for the pain (i.e. arthritis, metastatic cancer, diabetic neuropathy) have been identified and addressed.
2. Recommend an **Analgesic Trial** and titration of medications appropriate to the estimated intensity of pain (see [Appendix A](#)), analgesic history and pain assessment.
3. Recommend a trial of a regularly scheduled **non-opioid** for mild to moderate pain or an **opioid** for more severe pain.
4. If pain-related behaviors *improve/decrease*, assume pain was the cause and continue analgesic.
5. If pain-related behaviors *continue/escalate*, consider adding a low dose, short-acting opioid either regularly scheduled or PRN according to the patient/family/caregiver's goals for comfort/function and/or discomfort/behavioral indicators.
6. Use a "start low, go slow" approach to medication dosage and titration ([Appendix A](#)).
7. Follow the World Health Organization Analgesic Ladder step wise approach to increasing classifications of medications ([Appendix K](#)).
8. Schedule administration before anticipated pain episodes such as procedures, turning or mobilization in order to minimize behavioral responses to pain.
9. **Evaluate** the patient's response to analgesics by observing discomfort/pain behavior(s) at medication peak time.
10. **Evaluate** the effectiveness of analgesics using the **Pain Monitoring Standards**.
 - If the analgesic trial appears **ineffective**, do not assume that pain is not present. The dose may need to be titrated upwards before seeing an improvement in pain/discomfort indicators.
 - See [Appendix J](#): Pain Assessment & Management Algorithm
11. Document on discipline-specific notes pertinent information such as pain-related behaviors, triggers, pattern of escalation, and success of pharmacologic/non-pharmacologic approaches.
12. Recommend referral to a geriatric/pain/psychiatric or other specialist if behavioral/discomfort indicators do not subside within **48 to 72 hours**. See [Appendix H](#).

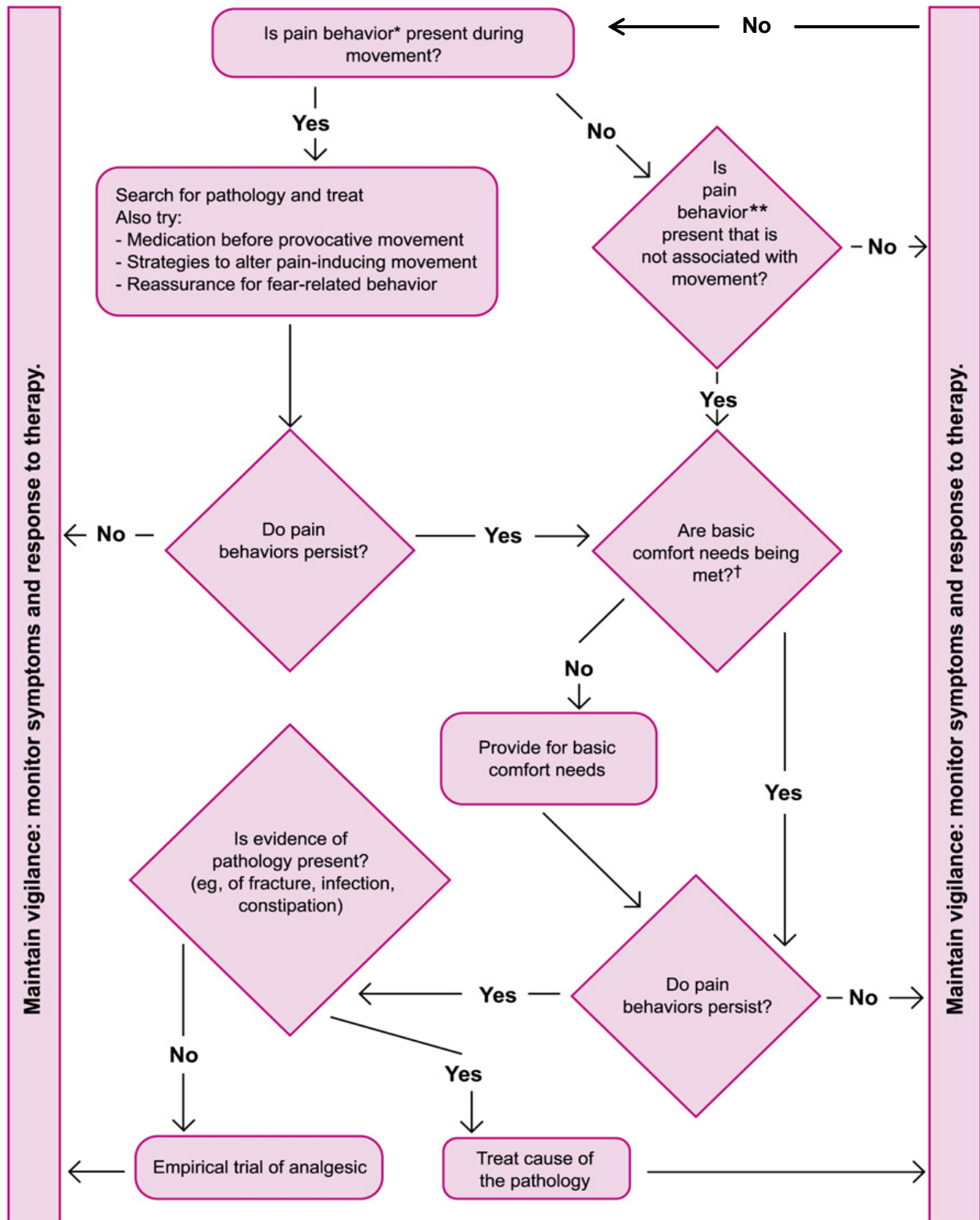
Adapted from: Herr et al, 2006, Pasero & McCaffery, 2011

Appendix I: Analgesic Assessment and Monitoring Standards

All patients started on an opioid/non-opioid Analgesic Trial (see [Appendix H](#)) will be assessed according to the **Pain Monitoring Standards**:

Pain Monitoring Standards	
1. The patient is to be assessed Q1H (sedation level and respiratory rate) X 12 hours, then Q2H X 12 hours, then Q4H/as per unit routine & PRN until:	<ul style="list-style-type: none"> Self-report, pain scale(s) and/or discomfort/behavior(s) indicate consistent pain relief Sedation level/respiratory rate, in response to the analgesic trial, is within normal limits for the patient. Anticipated side-effects of medications are minimized or absent.
2. The effectiveness of analgesia is evaluated by:	<ul style="list-style-type: none"> NonVerbal Behavior Indicators The discomfort/behavioral indicators, PAINAD score and/or the family/caregiver report indicate relief of pain. Verbal Indicators The patient verbally expresses that: <ul style="list-style-type: none"> their goals for comfort/function are attained, and he/she is satisfied with the pain management plan and/or FACES-R©, NRS or VDS consistently demonstrates lower scores of pain intensity
3. When Pain and Behavior is NOT controlled:	<ul style="list-style-type: none"> Assess self-report, pain scale, discomfort/behavior(s) and goals for comfort/function Q1H in addition to sedation level and respiratory rate. If the behavior(s) persists and/or escalates, continue non-opioid with/without opioid analgesics plus the addition of PRNs as ordered. If the pain-related behaviors do not decrease or the goals for comfort/function are not reached within 2 (two) hours, inform the Physician/NP and the interdisciplinary team. Request a referral to a pain/geriatric specialist as appropriate. See Appendix H. <p>Documentation:</p> <p>On appropriate interdisciplinary notes, document the pain-related/discomfort behaviors, triggers, pattern of escalation, and success/nonsuccess of pharmacologic/non-pharmacologic approaches.</p>
NOTE:	<ul style="list-style-type: none"> If the analgesic trial appears ineffective, do not assume that pain is not present. The dose may need to be titrated upwards before seeing an improvement in pain/discomfort indicators.

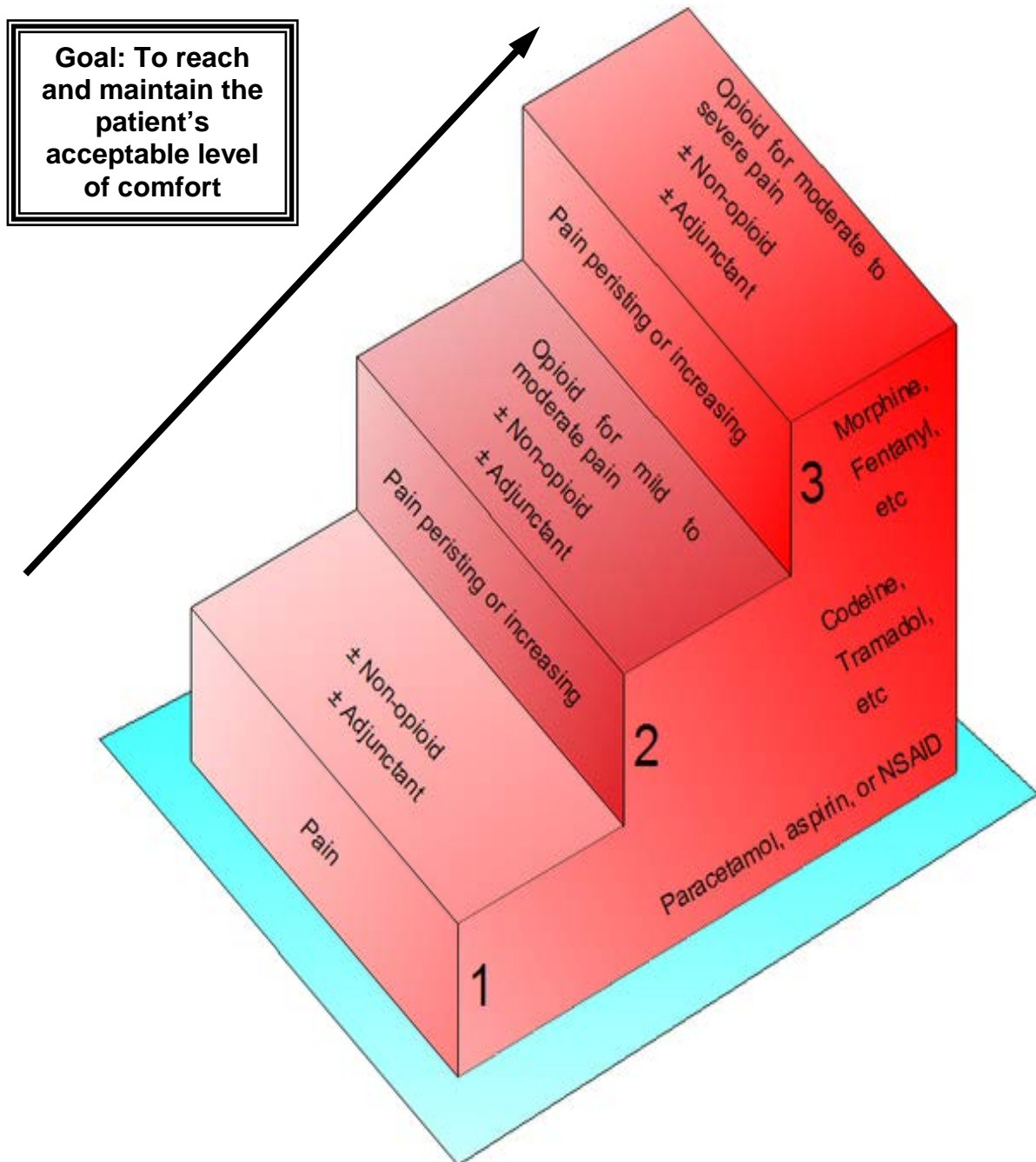
Appendix J: Pain Assessment & Management Algorithm



Source: American Geriatrics Society, 2009

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Appendix K: World Health Organization (WHO) Analgesic Ladder



WHO Step Care Approach [Figure22.2]. In Matheson & McConnell (2007). Gerontological Nursing Concepts and Practice (3rd ed. pp.720). Elsevier: St. Louis.