

# **PAIN ASSESSMENT IN OLDER ADULTS AT THE END OF LIFE**

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## **OBJECTIVES**

1. Identify barriers and challenges to pain assessment specific to caring for older adults
2. Discuss specific approaches to pain assessment that address the uniqueness of older adults, including those with mild cognitive impairments.
3. Identify specific approaches for evaluating presence of pain in frail nonverbal older adults with severe cognitive impairment (e.g. advanced dementia).

## **KEY WORDS**

Frail elderly, aged, assessment, measurement, barriers, cognitive impairment, pain scales, pain, dementia

## **OUTLINE**

Introduction: Assessment of pain in older adults, particularly frail older adults, requires special attention and strategies to assure accurate information is collected on which to base the plan of care. While much of the content included in the assessment process for the general population is relevant (See EPEC Module 3: Whole Patient Assessment and EPEC Module 4: Pain Management), gathering the information may require various adaptations and involvement of surrogates familiar with the older person. This module identifies approaches to assessment in the cognitively intact older adult, those with mild to moderate cognitive impairment, and finally, nonverbal, severely impaired older adults (e.g. with advanced dementia).

### I. Consequences of Unrecognized and Untreated Pain in Older Adults

Unrecognized and thus untreated (or under-treated) pain can have serious consequences in the quality of life of older persons. Unrelieved pain has been associated with altered immune function, impaired psychological function (e.g. depression, anxiety, fear), impaired physical function (e.g. impaired mobility and gait, delayed rehabilitation, falls), sleep disturbance, compromised cognitive function, and decreased socialization. These negative consequences interfere with older adults' quality of life, resulting in increased dependency and helplessness, as well as increased use of health care resources and ultimately costs.

### II. Barriers to Pain Assessment in Older Adults

A. Patient Related. Awareness of barriers that interfere with effective assessment and management of pain is important in developing a plan of care that promotes comfort in the older adult. Although older adults have diverse backgrounds and belief systems, there are a number of misconceptions and fears that have been commonly identified. Determining if any of these concerns exist can guide patient education facilitate more open communication about the presence of pain and willingness to adhere to treatment options. Assessment approaches also must be sensitive to the individual's culture and ethnicity, as well as individual beliefs and values.

1. Fear of addiction and tolerance to pain medication is especially prevalent among older adults and their families. Education on the differences between physical dependence and tolerance to analgesia (both expected and normal responses to long-term opioid use) and addiction (extremely rare in older adults, especially without history of substance abuse or addictive disease) should be provided (See EPEC Module 4: Pain Management for definitions and descriptions of tolerance, physical dependence, and addiction). Another related fear is concern that using opioids will lead to respiratory depression and arrest. Pain is a strong stimulant and although opioid analgesics can lead to initial sedation, respiratory depression is rare and can be prevented through careful monitoring and treated, if appropriate. Sedation is often mistaken for opioid overdose but can be a desirable state, allowing the older person to rest/sleep once pain relief is achieved or, in the case of terminal or intentional sedation, to escape the suffering associated with severe unrelieved pain at the end of life.
2. Some older adults have fears related to diagnostic testing required to evaluate reports of pain, hospitalization for diagnostic testing or treatment, and loss of independence and consequences of a serious diagnosis. Another common misconception is fear that if analgesics are used early, they will not work when pain is “really bad”. Identifying concerns underlying these fears regarding the pain diagnostic process can allow the provider to discuss strategies and provide assurances.
3. Many older adults, particularly males, come from a generation in which stoicism is common. Education on the negative effects of unrelieved pain (e.g. altered immune system and thus response to illness; mood disorders; impaired mobility; social isolation, etc.) can be helpful in gaining understanding about the importance of reporting pain and obtaining pain relief. Older persons also often believe that their primary care provider is omniscient and will know if they have any problems that can be treated and will treat them if they can. A related barrier is not wanting to be a bother to the physician. The importance and desirability of the older person and/or caregiver being a partner in communicating symptoms and related factors to the health care provider should be stressed.
4. Presence of multiple comorbid medical problems complicates assessment in older adults, who often suffer multiple pain conditions. This leads to complexity in evaluating and treating pain complaints with different etiologies requiring different pharmacologic intervention approaches (e.g. nociceptive and neuropathic pain problems). A careful history and examination of each pain report/location is essential.

Depression, dementia and delirium are common conditions in older persons, particularly at the end of life, and can complicate the assessment process. Recognizing the presence of depression through appropriate screening can guide therapeutic intervention. It also is important to differentiate delirium and dementia, in order to treat identifiable and reversible etiologies.
5. Sensory and cognitive impairments can impact assessment of pain in older adults. Adaptations for sensory alterations (e.g. prescriptive lenses, hearing aids) should be in place and approaches to assessment should include adaptations to overcome such barriers.

#### B. Health Care Provider Related

Many health care providers are unprepared to assess and evaluate pain in older adults, as education content in physician, nurse and other health care provider curriculum has historically provided limited content on changes in aging that impact assessment approaches. Additionally, many hold misconceptions regarding the presence and severity of pain in the older population, as well as the safety of treating pain, particularly in those with cognitive impairment. Misbeliefs that older persons experience less pain, that pain is expected as we age and should be “lived

with,” and that it is not safe to use analgesics in older persons must be confronted. Content related to approaches to pain assessment and treatment in older adults important in education of health care providers will be highlighted in the remainder of this module.

### C. Health System Related

A number of barriers in the health care systems caring for older adults interfere with effective pain assessment and management. Careful and regular evaluation for the presence of pain and its relief following intervention is key. However, palliative care and pain management has not been high priority, particularly in long term care (LTC) facilities. Depending on the setting, involvement of professional health care providers in regular care and assessment of older adults often is limited. Hospice services are accessed late, if at all. Access to diagnostic services is limited, particularly in LTC. Low staffing patterns and turnover of nonprofessional caregivers make it difficult to keep educated individuals on the front line and to assure consistent communication of assessments (if they occur). Increasing institutional commitment to aggressive pain management in older adults at the end of life is essential. Access to hospices services and appropriate diagnostic services will enhance pain assessment. Education of nonprofessional providers interacting closely with older persons and provision of staffing and communication systems that facilitate assessment and communication of assessment and reassessment findings is needed.

## III. Approaches to Pain Assessment in Cognitively Intact and Mild-Moderately Cognitively Impaired Older Adults

Pain can be assessed in older persons by considering factors that may require alterations in the approaches used. Following are suggestions for strategies that can increase the likelihood of obtaining valid and reliable information on which to base treatment decisions.

### A. Collecting Information from Older Persons

1. Assessment content. The overall content for inclusion in a complete assessment of pain at the end of life discussed in EPEC Module 3: Whole Patient Assessment is mostly applicable for use with older adults. However, there are some areas in which the uniqueness of physical and psychological changes occurring with aging should be considered.

2. Adaptations in gathering self-report data. Most cognitively intact older adults and many with mild to moderate cognitive impairment can provide a reliable self-report of the presence of pain and its severity or intensity. Because there is evidence that surrogate reports of pain are not accurate, assessment information should be gathered directly from the older person whenever possible. However, knowledgeable individuals with a close relationship to the older person (family, friends and significant others) may be better able to interpret expressions of pain (e.g. facial expressions, behavior changes) and provide information on prior pain conditions that may be useful in detecting possible sources of current pain.

3. Use of terms synonymous with pain. Asking the simple question “Do you have pain?” often results in a “negative” response in older persons. Many do not identify with or acknowledge the “pain” terminology, but will respond positively when questioned using other terms such as aching, hurting, soreness or discomfort. Thus, various terms should be used before ruling out pain presence if a negative response is initially obtained to questions about “pain.” The preferred word choice should be used in subsequent assessments and reassessments.

4. Selecting reliable and valid pain scales. It is important to select a standardized pain scale that has been validated for use with older persons, one that the patient understands and can

respond to. A number of pain intensity scales are available that have been evaluated for use with older adults, including those with mild to moderate cognitive impairment. The 0-10 numeric rating scale (NRS), when offered in a written format and vertical presentation, is a useful tool in older patients, and, given its established use in most institutions, can be tried first. However, many older persons prefer to use a verbal descriptor scale (VDS) to represent the presence and severity of pain and the VDS is a valid and reliable tool in mild and moderately cognitively impaired older adults. An adaptation of the VDS that includes a pain thermometer can also be useful. A faces pain scale is another tool that can be considered and may be useful if language barriers are present. Older persons vary in regards to ease of understanding tools and which one best reflects their pain experience, thus it is important to have different formats available. Selecting a scale and then using it consistently in reassessments across health care providers is important. (See Appendix A: Example of Pain Scales for Use with Older Adults)

5. Adapting instruments to accommodate sensory impairments. Because of visual (e.g. presbyopia, age-related changes in color vision, senile miosis, and blindness from cataracts, glaucoma, macular degeneration and diabetic retinopathy) and sensory impairments (e.g. hearing loss and impairment from sensorineural disease, conductive disorders, and mixed or central hearing loss) common in aging, it is wise to consider approaches that address these impairments. Providing written instructions for scale use and enlargement of both images and words/numbers on standard scales can be helpful. A minimum of 14-point font should be used, as well as darkened lines and images. Avoid glare from bright lights and use pain scales printed on buff colored paper. Also, those with hearing impairment will be aided by assuring minimal background noises and distractions and use of aids during the evaluation process.

6. Process of evaluating pain. Instructions for use of pain scales and reporting pain presence should be provided with each interaction. Repetition can be very helpful and essential for some patients, as older adults with cognitive impairment have difficulties with recent memory. Thus, the common assessment approach of asking the person to compare to prior pain reports (such as How does your current pain compare to yesterday? How much pain relief did you obtain? How severe was your pain in the past week?) is likely to provide inaccurate responses. Pain should be evaluated in the present and reassessed regularly.

## B. Focus on identification of pain etiologies

1. Frequency of multiple pain problems. Older persons often experience multiple diseases and/or conditions that can have an associated pain component. Although this can complicate the assessment process, it is necessary to explore each individual complaint or report of discomfort. Different treatment approaches may be needed depending on the various pain problems identified. Decision-making regarding diagnostic and treatment strategies will be impacted by several factors including: 1) the older person's life expectancy, 2) possibility of a treatable underlying cause of pain (e.g. pain due to bowel obstruction that could be relieved by ocreotide), and 3) possibility that a cause may be found that would dictate a very different treatment (e.g. presence of nerve compression that might respond to steroids rather than just higher doses of opioids). For example, for the older person in the last few weeks of life with end-stage dementia and untreatable bone cancer, conducting a complete diagnostic workup related to suspected compression fractures of the spine might be undesirable. However, the older person with end-stage COPD and several months life expectancy may benefit from a diagnostic workup related to new burning pain in lower extremities to target interventions to the specific etiology.

2. Recognizing and assessing common pain problems. A number of chronic pain problems are more prevalent in older adults and should be considered when exploring causes of reported pain symptoms. Up to 80% of older adults experience osteoarthritis, making it one of the most common reasons for pain in this population. Other conditions that should be considered include inflammatory arthritis, neuralgias (e.g. post-herpetic neuralgia, trigeminal neuralgia), peripheral neuropathy (ischemic and diabetic), temporal arteritis and polymyalgia rheumatica, osteoporosis-related compression fractures, low back pain, spinal stenosis, old and undiagnosed fractures, myofascial pain syndromes, post-stroke syndrome, phantom limb pain and many types of cancer. Chronic pain problems may contribute to overall pain and suffering in persons with a terminal disease and need to be identified and addressed.

3. Present pain complaint. Evaluation of the present pain complaint includes the same factors discussed in EPEC Module 3: Whole Patient Assessment relevant to diagnose pain etiology and develop the plan of care. Identifying the location of pain is important, often done through questioning, pointing to one's own body part or use of a body map. Older persons, including many with mild-moderate cognitive impairment, can indicate pain location.

4. Pain History, Physical Examination and Lab/Diagnostic Testing. When possible, a thorough pain history can focus the examination on those problems most likely related to the current pain problem. Pain history components are similar to those presented in EPEC Module 3: Whole Patient Assessment.

a. Complete examination of pain source(s). A thorough physical assessment is needed to establish the potential diagnosis and develop the initial intervention plan. Physical examination techniques should focus on prevalent pain problems and be appropriate to each location of pain determined in the history or report from family or health caregiver. Because of the prevalence of musculoskeletal and neurological disorders in older adults, examination techniques should focus on these two systems, in particular, when searching for possible causes of discomfort. Examination for tenderness, trigger points, inflammation, deformities, posture, leg length discrepancy, and impaired mobility can help with diagnosis of musculoskeletal conditions. Specific maneuvers such as straight-leg-raising and joint motion may be useful in establishing a diagnosis. Neurologic examination should include a search for weakness, hyperalgesia, hyperpathia, allodynia, numbness, paresthesias, and other neurologic impairments.

b. Distinguish new pain from persistent problems. Older persons may present with a number of persistent problems that require continued evaluation and treatment, as well as new problems. Differentiation of the varied pain sources is necessary to guide effective treatment.

c. Lab/Diagnostic evaluations. Because of issues related to discomfort and cost, laboratory and diagnostic examinations should only be ordered if they are necessary to establish a diagnosis and will impact treatment decisions. The older person's place on the disease trajectory and established goals of care influences the utility and necessity of diagnostic procedures. For example, there is no strong rationale for ordering an MRI in the older person with potential spinal stenosis that is not eligible for surgical intervention. On the other hand, imaging can be useful to identify a likely treatable cause of pain (e.g. cord compression, nerve compression or bowel obstruction) or a cause that will redirect the treatment plan.

5. Analgesic history. In addition to using an average of 7 prescription medications, the use of OTC products by older adults is high and can complicate the overall medication regimen. Gathering information from the patient on ALL medications taken, including OTC and natural homeopathic products, is essential. The complexity of potential drug-drug interactions necessitates the pharmacist's involvement in the plan of care. The more complicated the

medication regimen, the less likely that adherence to the plan will be accomplished. Reviewing for drugs that can be discontinued and evaluation of administration approaches that simplify the regimen can be useful. Adding an analgesic to a medication regimen that is already complicated may result in either missed doses of around-the-clock (ATC) agents or not taking the ordered analgesics at all.

6. Information related to prior experiences. Part of the pain history includes gathering information about prior pain experiences and interventions that have been helpful in the past. This same approach is useful with older adults, but involvement of significant others may be necessary to gather prior use information. Often older persons have coping strategies that have been previously useful in addressing pain problems and can be incorporated into the treatment plan. For example, use of BenGay or other counterstimulant products may be a well-received adjunctive therapy for moderate joint pain related to osteoarthritis. Use of alternative therapies is also common among older adults in coping with chronic pain. Respecting the older person's prior experiences and preferences, and evaluating alternative therapies used for potential harm and cost complete the pain history. Alternative therapies that are not harmful and/or costly should be explored and used if they provide pain relief and do not interfere with the proposed treatment plan.

D. Overall Quality of Life. As discussed in the EPEC Module 3: Whole Patient Assessment, determination of the overall impact of pain on functional and psychological function is important in determining intervention approaches, as well as monitoring for improvement and deterioration, particularly at the end of life. This again is an assessment approach that is important to all populations, but the tools and approaches to evaluate functional changes vary for older persons. For patients whose status does not allow them to respond to questionnaire approaches, using simple questions can be very helpful in evaluating the impact of pain in areas of importance to the older person. For example, "What would you like to do that your pain keeps you from doing?"

1. Physical and psychosocial function. Identifying domains of daily life that pain is interfering with and which the patient would like to see improved (either spontaneously volunteered or from directed questioning using the BPI items as a template) can be very useful in establishing goals for the treatment plan and monitoring for changes in status. For example, "How is your pain interfering with your physical abilities and mobility?" and "What effect does the pain have on your mood, participation and enjoyment of social activities?" Or "Pain can really interfere with the way people live, in a lot of different ways. Can you tell me how your pain is interfering with the way you live? What bothers you the most?" Summarizing their concerns and validating the importance of the problems identified is useful and allows opportunity to demonstrate that you are listening and care about their individual needs. For example, "It sounds like your pain is most bothersome to you because it keeps you from getting a good night's sleep and because it puts you in a bad mood all day, so you can't spend time with your grandchildren. Let's see what we can do about that." Standard approaches to evaluate functional abilities are often part of the routine evaluation in geriatric assessments and may be useful, depending on the older person's position in the illness trajectory. These include observing ROM and performance of ADLs and mobility performance that can be aided with more formal measures of disability such as the Tinetti Get-up-and Go Test, the Katz ADL Scale,

the Lawton Instrumental Activities of Daily Living Scale, or the Functional Independence Measure (FIM).

Pain can affect mood and social functioning; failure to recognize and treat underlying psychological conditions, particularly depression, may result in ineffective pain management. The presence of depression can increase pain complaints and persistent pain can increase depression; thus, determining presence of depression is key in guiding the therapeutic treatment plan. Recognizing depression can be difficult in the older person with persistent pain at the end of life because many somatic complaints of depression (e.g. fatigue, difficulty sleeping, loss of appetite, weight loss) are also common to other disorders, including pain. However, screens that focus on the psychological symptoms of depression (e.g. dysphoric mood, hopelessness, worthlessness, guilt, suicidal ideation) can help differentiate the presence of depression and pain. A brief psychological test developed to screen for depression is the short form of the Geriatric Depression Scale. Anxiety can also significantly impact pain and suffering and should be evaluated. Part of the psychosocial assessment also should gather information on the older person's relationships/supports, coping skills, anxiety, fears and beliefs regarding pain and its treatment that can impact treatment decisions.

Use of a standardized comprehensive assessment tool that addresses the impact of pain on specific aspects of life activity and quality of life is another approach that focuses specifically on pain and its impact. Most notable for persons at the end of life is the Brief Pain Inventory (BPI) developed for use with cancer patients and validated for use with older adults. This tool gathers information on pain severity and its impact on ten areas of function. (EPEC Module 3: Whole Patient Assessment: Appendix A). Another tool that is easily administered and requires limited time on the older person's part is the Pain Disability Index. Both of these tools ask the patient to rate the impact of current pain on various aspects of quality of life. The use of these tools in older persons with cognitive impairment has not been established.

2. Cognitive status. Because of the increasing incidence of cognitive impairment in older persons, especially in those at the end of life, it is important to determine its presence and severity (including delirium and dementia). This has implications for approaches to assessment and selection of treatment options. Many nondrug interventions require cognitive processing and would not be feasible in the cognitively impaired older adult. A number of screening tools are available that can quickly evaluate mental status, with the Mini-Mental State Examination (MMSE) and the Mini-Cog commonly used. The Confusion Assessment Method (CAM) is a screening approach specifically focused on delirium identification which includes BOTH acute onset and fluctuating course AND inattention AND EITHER disorganized thinking OR altered level of consciousness. It is important to differentiate delirium from dementia, a task that is difficult because they often coexist. Typically, dementias follow a stepwise progression over time with persistent symptoms and exhibit normal sleep-wake cycles and level of consciousness. Orientation is often impaired and aphasia and apathy are common with autonomic and physical changes unusual. By contrast, delirium presents acutely with fluctuations in level of consciousness over time. Sleep-wake cycle is often disturbed and the older person has difficulty attending to task. Autonomic changes are common, language may be incoherent, and fear and agitation may be present. Obtaining a history from family members or caregivers to determine the onset of symptoms can be helpful in differentiating disorders. The older patient is predisposed to delirium by a number of factors including age-related brain changes and damaged brain function, sensory impairments, polypharmacy and altered pharmacokinetics leading to increased drug interactions and/or adverse effects, multiple comorbid diseases, and altered

nutrition and fluid intake. Treatment of delirium involves identification of the underlying etiology and managing symptoms (See EPEC Module 6: Depression, Anxiety and Delirium).

F. Other. As with younger individuals at the end of life, it is important to evaluate the social support system (including availability and relationships with caregivers, family, friends and significant others), the cultural environment, spirituality and its importance to the older adult and family, financial concerns and accessibility to needed healthcare resources. Some elders and their families may also benefit from support groups.

#### IV. Assessment Approaches for Older Persons with Advanced Dementia/Nonverbal

A. Pain in persons with severe dementia. There are many misperceptions regarding pain in persons with advanced dementia. Studies to date show that persons with dementia experience the same pain sensation as those who are cognitively intact. However, those with dementia have altered affective responses to pain probably due to their inability to cognitively process the sensation in the context of prior pain experience, attitudes, knowledge, and beliefs. Given this, reactions to painful sensations may be different from a typical response expected from a cognitively intact older person. For example, constipation can cause great distress in the cognitively impaired elder and may lead to aggressive or agitated behaviors. Most important, one should assume that any condition that is painful to a cognitively intact person would also be painful to those with advanced dementia who cannot express themselves. This has implications for the recognition and management of pain in this population.

B. Observing for nonverbal pain indicators and changes in usual behaviors/activities. Because most persons with advanced dementia are unable to verbally report their pain experience, observation of behaviors and activities that may indicate pain is a key assessment strategy. Caregivers should be alert for the presence of typical pain behaviors, as well as those less obvious and not usually attributed to pain. Typical pain behaviors include rubbing, guarding, moaning, groaning, crying, grimacing, and frowning. More subtle and less specific nonverbal indicators may include facial expressions (e.g. distorted expressions, rapid blinking, frightened face), verbalizations/vocalizations (e.g. grunting, chanting, verbally abusive, yelling out), body movements (e.g. fidgeting, increased pacing or rocking, rigid posture), changes in interpersonal interactions (e.g. aggressiveness, resisting care, disruptive, withdrawn), changes in activity patterns or routines (e.g. sudden cessation of common routines, refusing food, increased sleep, increased wandering), and mental status changes (e.g. increased confusion, irritability, distress). It is important to recognize that pain indicators may be absent in patients at rest, but this does not suggest that the pain is gone. Patients should be observed for presence of pain-related behaviors during movement (e.g. transferring, bathing).

Monitoring for changes in behaviors and usual activities in persons unable to communicate can be a useful strategy for identifying potential pain problems. For example, consider pain as one potential etiology if the older person with advanced dementia shows decreased activity or increased activity, change in appetite or intake, change in mood, increased agitation or restlessness, increased pacing or wandering, combativeness or aggressive behaviors, withdrawal or isolation, increase in verbal outbursts/screaming. Subtle changes in usual patterns of behavior suggest possible presence of pain and a thorough evaluation for potential pain-causing problems should be conducted.

C. Use of surrogate reporters. It can be difficult to recognize that certain behaviors may indicate pain if the health care provider is unfamiliar with how the older person usually behaves.

Caregivers, whether healthcare providers or family members, can be very helpful in recognizing changes in persons with dementia that might indicate pain. However, surrogate reporters must have preparation and training regarding the types of behaviors and activity changes that might indicate pain. Although familiar with their loved one or patient, the caregiver might be unaware of potential relationships between behavior patterns and potential pain conditions. Caregivers with the most direct and long-standing relationship with the person with dementia are in the best position to recognize subtle changes and communicate those to the health care provider. Involving caregivers in the plan for assessment of pain is imperative, if possible.

D. Search for potential causes of discomfort. When pain is suspected, a search for potential causes is important in order to guide treatment decisions. Common problems (e.g. constipation, inflammation, infection, fractures, pressure ulcers) or procedures (e.g. dressing changes) that are known to be uncomfortable should be considered as possible causes of suspicious behavior. If the patient has a disease process that would be probably be painful to others who can verbalize, assume it is painful for the person with dementia. Efforts should focus on treating any identifiable pathologies and premedicating prior to painful procedures.

E. Trial nonpharmacologic and/or analgesic interventions as assessment strategy. If pain is suspected but no treatable etiology is identified, initial intervention approaches should include basic comfort measures (such as positioning, toileting, soothing communication, addressing hunger and thirst, managing environmental stimuli). If these measures do not alter the suspected behaviors, an analgesic trial is warranted as an assessment strategy. Because it is difficult to determine level of pain severity in persons with advanced dementia, selection of an appropriate analgesic to use as an approach to verifying pain is the etiology for suspected behaviors is challenging. The few studies that have examined use of an analgesic trial start with a nonopioid such as acetaminophen 500-1000mg TID. Assess the effectiveness of the analgesic in relieving pain during the peak effect of the selected analgesic. However, titration to stronger drugs and higher doses may be necessary before ruling out pain as the etiology for behavior/activity changes. If behavioral changes persist or intensify, continue to rule out other causes (such as delirium, adverse effects of treatment, drug metabolite accumulation) and focus treatment on other suspected causes. If interventions appear to result in pain relief (e.g. decreased agitation or restlessness), assume pain was the likely cause and continue pharmacologic and/or nonpharmacologic interventions. An algorithm presented in the AGS Persistent Pain Guideline can be useful (See Appendix B).

## V. Reassessment Strategies

A. Timing issues. Reassessment of pain and other symptoms should be conducted at regular intervals at times that relate to the anticipated peak and duration of administered analgesics. With moderate to severe acute pain, assessments may be needed every one to two hours unless sustained relief is obtained through drug titration. Use of the same assessment approach or tool(s) is important to monitor intervention effectiveness. Reassessment should include evaluation of the effectiveness of interventions, presence of side effects and adherence to the treatment regimen. Patient and family preferences should be considered in developing and adapting the treatment plan. Use of a pain log or diary completed by the older person or their caregiver can provide useful information regarding the pain, changes in pain, and responsiveness to selected interventions.

B. Communication with other providers and/or caregivers. A key aspect of effective pain management in older persons (and any patient population) is communication of assessment information. Particularly in patients for whom suspected behaviors and activity changes are determined as pain-related, the approach to assessment selected (e.g. pain thermometer or numeric rating scale or behavioral observation) and any specific behaviors or activity changes being monitored must be communicated to other health care providers and caregivers. This information exchange is particularly important for continuity of care when the older person with advanced dementia is moving between care providers and/or care settings.

#### VI. Setting Specific Concerns/Issues

A. Communication across care settings. Maintaining comfort in older persons with dementia can be challenging when the patient is transferred across care settings. Recognition of subtle changes in behavior is difficult for anyone without an ongoing history/knowledge of the individual older person's usual behavior pattern. As noted above, communication of behaviors and/or activity changes that are suspected as pain-related is necessary. Development of a transfer document that incorporates this individualized assessment information would be helpful in assuring communication of essential information.

#### **KEY POINTS**

1. Older persons and caregivers/families often harbor myths and misconceptions about pain and its treatment that must be recognized and debunked.
2. Older persons often have multiple persistent pain problems that must be considered in evaluation of new and ongoing pain conditions.
3. Pain can be assessed in many older adults using similar approaches as those in the general population.
4. Many older persons with mild to moderate cognitive impairment can reliably self-report pain presence and/or intensity; thus, attempts should be made to gather self-report of pain in all older persons able to communicate.
5. Valid and reliable pain scales and comprehensive tools are available for use with older persons.
6. Pain assessment scales/tools should be adapted to address common aging changes that impact ability to perceive and respond effectively (e.g. visual, auditory, motor and cognitive impairments).
7. When assessing older persons with cognitive impairment, asking about current pain rather than comparing with earlier pain reports is necessary
8. Alternate strategies are important when assessing pain in older persons who cannot communicate their pain and/or other sensations.
9. Subtle pain behaviors and/or changes in routine/activities may be indicators of the presence of pain, particularly in those with advanced cognitive impairment.
10. Use of pain treatments (e.g. pharmacologic and nonpharmacologic approaches) play a key role in evaluating for the presence of pain in persons that cannot communicate.
11. Involvement of family and/or caregivers may be useful in recognizing changes in behavior/activities that may suggest the presence of pain.
12. Regular reassessment is essential to evaluate and monitor response to pain interventions and to recognize return of pain and/or new pain problems.

13. The same scale and behavioral manifestations used to identify pain in older persons should be used in evaluating effectiveness of interventions.
14. Identified pain behaviors (specific and nonspecific) must be communicated to other health care providers and across care settings.
15. Family members and caregivers will need education on the relationship between behavioral and activity changes and pain, to facilitate their help in pain assessment.

### **PEARLS**

1. The most common reason that pain is under-treated in older adults is failure to assess it.
2. Many older persons can reliably report their pain—attempt to gather their report and believe it.
3. If behavioral changes are noted, assume pain is present until proven otherwise.
4. If you would experience pain in the similar circumstances, assume the nonverbal cognitively impaired person would as well.
5. Teach caregivers how to assist in the assessment process.
6. Communicate, communicate, communicate—with patients, with family/caregivers, with other health care providers.

### **POTENTIAL PITFALLS**

1. Assuming that older persons, especially those that cannot communicate, do not experience pain.
2. Assuming that older persons are unreliable reporters of their own pain experience.
3. Failure to gather information on older person's and/or caregiver's attitudes and knowledge about pain and its treatment.
4. Lack of knowledge regarding pain conditions common in older adults.
5. Lack of knowledge regarding changes with aging that requires adaptation in the assessment process.
6. Use of excessive and/or unnecessary diagnostic tests that will not impact the plan of care.
7. Failure to complete a thorough physical examination of sources of pain.

### **RESOURCES**

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