Challenges in Pain Assessment in Cognitively Intact and Cognitively Impaired Older Adults With Cancer

Carol P. Curtiss, MSN, RN-BC

Purpose/Objectives: To describe approaches to pain assessment in cognitively intact and cognitively impaired older adults with cancer.

Data Sources: MEDLINE® literature search, personal reference collection, and clinical experience.

Data Synthesis: A systematic and comprehensive pain assessment is the cornerstone of effective treatment strategies. Determining the effect of pain on older adults' ability to function is as important as rating pain intensity. Evidence-based recommendations exist to guide practice.

Conclusions: The undertreatment of pain in older adults persists despite a plethora of published guidelines addressing pain assessment and management. Unrelieved pain affects recovery from illness and all aspects of life. Systematic and ongoing assessment is elementary to effective pain management, yet assessments frequently are neither completed nor documented. Because pain is subjective and individual responses to pain interventions vary widely and are unpredictable, assessment is vital to comprehensive pain care in all clinical settings. Reliable and validated pain assessment tools for cognitively intact and cognitively impaired older adults are available to guide practice.

Implications for Nursing: Pain assessment is a core competency for nurses in all clinical settings. Comprehensive, individualized, and ongoing assessment provides the information necessary so that clinicians can develop interventions to relieve patients' pain and improve their quality of life. Nurses have the knowledge, skills, and tools to adequately screen and comprehensively assess pain in older adult patients, including those with cognitive impairment. By using this knowledge, nurses can change systems and practices, have a significant effect on improving pain care, and increase quality of life and function of older adults with pain.

Many people with cancer fear pain more than the disease itself. Yet most cancer pain can be relieved with rather simple strategies that are outlined in published evidence-based guidelines (Gordon et al., 2005; Miaskowski et al., 2005; National Comprehensive Cancer Network, 2009; Pergolizzi et al., 2008). Guidelines recommend universal screening of all patients to identify the presence of pain at the initial encounter; the patient's self-report should be the foundation for ongoing assessment. The guidelines highlight the importance of a continuous process of comprehensive assessment as the first essential step in managing pain.

Although pain assessment and management are core competencies for every nurse in any clinical setting (American Society for Pain Management Nursing, 2010; Paice et al., 2006), failure to assess pain is a common and significant barrier to pain management (Miaskowski et al., 2005). Comprehensive, individualized, and ongoing assessment provides the information necessary for clinicians to develop interventions to relieve pain and improve patients' quality of life.

Pain is a highly individualized experience, but assessment in older adults is similar to assessment in younger adults, with accommodations to address age-related changes and potential cognitive decline. Lack of comprehensive pain assessment increases the risk of undertreatment of pain in older adults with cancer. The purpose of this article is to describe best practices for assessing pain in older adults, including those with cognitive impairment.

The Undertreatment of Pain in Older Adults

Pain is not an inevitable consequence of aging, but it is prevalent among older adults. Cancer pain and persistent pain from chronic illnesses are common, and acute pain is frequent during and after many therapeutic and diagnostic procedures. When caring for older adults with cancer, healthcare professionals must assess cancer pain and treatment-related pain as well as other sources of pain that may be unrelated to the diagnosis of cancer. Older individuals have an increased risk for developing pain-causing conditions and illnesses (e.g.,

osteoarthritis, rheumatoid arthritis, back and neck pain, postherpetic neuralgia, diabetic polyneuropathy, post-stroke syndrome). Pain with different etiologies may require distinctive treatments for effective care, making comprehensive assessment essential.

Failure to recognize and assess pain is a primary reason for undertreatment of pain. In a study of older adult patients in an emergency department, 34% did not have their pain severity quantified by an objective pain assessment (Herr & Titler, 2009). The Joint Commission lists pain assessment and reassessment of responses to treatment among the top five areas for improvement. Assessment of individuals with pain is essential to pain management. Yet pain assessment often is neglected, and clinicians frequently start treatment without sufficient knowledge of people's pain and other critical information about their pain experiences. Systematic, routine, and individualized screening for pain and comprehensive pain assessment for those who report pain are elementary to competent pain care.

Despite a plethora of published guidelines regarding pain assessment and management (American Geriatrics Society [AGS] Panel on Persistent Pain in Older Persons, 2002; AGS Panel on the Pharmacological Management of Persistent Pain in Older Persons, 2009; Morrison et al., 2003), undertreatment of pain persists in all clinical settings, including hospice. A survey of 347,555 hospice patients with a mean age of 75.3 years found that 26% of people with two or more pain assessments rated their last pain intensity score as moderate to severe (Strassels, Blough, Hazlet, Veenstra, & Sullivan, 2006). Evidence of undertreatment of pain in long-term care and in the community is clear (Bernabei et al., 1998; Morrison et al., 2003; Won et al., 2004). Older, frailer, and more cognitively impaired people tend to receive the least treatment for pain, even though that population has the greatest need for assistance (Bernabei et al., 1998; Husebo et al., 2008; Reynolds, Hanson, DeVellis, Henderson, & Steinhauser, 2008).

Untreated and undertreated pain affects recovery from illness; has a physiologic effect on every body system, including immune responses; and threatens all aspects of quality of life (AGS Panel on Persistent Pain in Older Persons, 2002; Peltier & St. Marie, 2010). Evidence suggests that older individuals with pain, especially those who have chronic pain conditions, have an increased risk for falls—a problem with serious health consequences, including reduced life span (Chaiwanichsiri, Janchai, & Tantisiriwat, 2009; Leveille et al., 2009). Depression, sleep deprivation, and anxiety can increase pain perception and are comorbidities commonly noted with persistent pain (AGS Panel on Persistent Pain in Older Persons, 2002). Social isolation, mood changes, and reduced appetite, mobility, and energy are other potential negative consequences of unrelenting pain (AGS Panel on Persistent Pain in Older Persons, 2002). Individuals with mild to moderate cognitive impairment may show cognitive decline while trying to cope with pain (Schuler, Njoo, Hestermann, Oster, & Hauer, 2004).

Barriers to Assessing Pain in Older Adults

Misperceptions about older adults and pain are common. Many people erroneously assume that older adults are less sensitive to pain, are more tolerant to painful stimuli, and cannot use opioids for pain relief (Miaskowski et al., 2005). Another common misconception is that people with dementia or low cognitive abilities do not experience pain or experience pain less than cognitively intact adults. Thus far, studies of people with dementia have discredited such beliefs (Bjoro & Herr, 2008). The neuropathology that causes Alzheimer disease leaves intact the areas of the brain that interpret stimuli as painful (the somatosensory cortex) (Bjoro & Herr, 2008). Individuals with cognitive impairment may experience pain similarly to others but may have difficulty interpreting the meaning of the sensation and exhibiting the appropriate affective response (Herr, Coyne, et al., 2006). Many older adults have multiple sources of pain, multiple comorbidities, and a higher prevalence of dementia, disabilities, and sensory impairments (AGS Panel on Persistent Pain in Older Persons, 2002). Older adults may report pain more often and have more potential sources of pain than their younger counterparts (AGS Panel on the Pharmacological Management of Persistent Pain in Older Persons, 2009). Older age is associated with changes in hearing, vision, and cognition, which add additional challenges to pain assessment.

Most clinicians rely on acute pain behaviors; indicators such as moaning, groaning, grimacing, and muscle guarding; and changes in vital signs to determine the presence of pain. Such behaviors result from the activation of the sympathetic nervous system and the "fight or flight" response. With persistent pain, this heightened sense of awareness disappears as the sympathetic nervous system attenuates and no longer produces signals that lead to changes in vital signs. Physiologic indicators (e.g., heart rate, blood pressure, respiratory rates, diaphoresis) cannot reliably indicate the presence or absence of persistent pain (Herr, Coyne, et al., 2006). Pain assessment is further complicated by the fact that people with persistent pain, including cancer pain, often do not "look" as if they are in pain. They can exhibit a flat, mask-like expression that varies very little, regardless of mood, distress, or pain intensity (AGS Panel on Persistent Pain in Older Persons, 2002).

Individuals with cognitive impairment have even more blunted affect and nonexpressive facial expressions than others with persistent pain (AGS Panel on

Persistent Pain in Older Persons, 2002; Herr, Coyne, et al., 2006). In addition, behaviors caused by other problems such as distress or hunger may mimic those related to pain. Determining whether people have persistent pain simply by looking at them or relying on acute pain behaviors is impossible. A study of cognitively intact and cognitively impaired older adults with chronic low-back pain highlighted the differences in the behavioral presentation of individuals with different levels of cognitive impairment (Shega et al., 2008). Cognitively intact patients displayed less guarding ($p = 0.02$) and rubbing ($p < 0.001$) but more bracing behaviors ($p = 0.03$) than patients with impaired cognition. People of all cognition levels with higher pain levels had greater grimacing ($p < 0.001$) and guarding ($p = 0.02$) (Shega et al., 2008), suggesting that in the acute care setting, grimacing may be a key behavior to consider. However, the results cannot be generalized to other settings.

Many individuals avoid discussing pain unless they are asked about it directly. They may not want to complain, may assume pain is an inevitable consequence of cancer or aging, or may not realize that pain can be ameliorated. They may wish to be considered "good" patients or may hope to prioritize their care—focusing on cancer treatment or other issues rather than pain during their visits with healthcare providers. Older individuals tend to underreport pain despite substantial impairment (AGS Panel on Persistent Pain in Older Persons, 2002).

Screening for Pain in Older Adults

Routine scheduled screening of all patients and comprehensive assessment and reassessment of those with pain are the essential steps of effectively treating pain, regardless of clinical setting. Figure 1 reviews the steps involved in pain assessment and management. Written policies should assign responsibility for pain screening and assessment, include a time frame and schedule to screen all patients for pain, and identify a rating that requires reassessment and planning; an example of the latter is, "On a scale of 0–10 (0 = no pain to 10 = worst possible pain), pain reported as 4 or higher or any intensity unacceptable to the patient requires further assessment and planning." Such a trigger provides for prompt reassessment and changes in the pain management plan before pain is likely to affect activities of daily living.

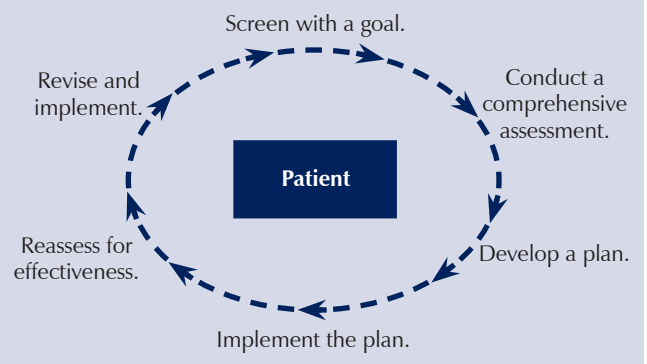

Figure 1. Clinical Process: Pain Assessment and Management

Screen each individual routinely for the presence of pain or discomfort. Use a variety of words to ask about pain. Patients typically reserve the word "pain" to indicate only severe pain and use words like "hurt," "sore," or "discomfort" to describe less-intense pain. Obtain pain intensity ratings and observe the person resting and moving. Use a reliable and valid pain intensity rating scale and track responses over time to evaluate progress. Be sure the patient understands how to use the scale and how the information will be used. Observe the patient carefully for discrepancies between pain ratings and function, mobility, or behavior. When discrepancies exist, ask the patient to help clarify the differences. Although many people are stoic and underreport pain, others may believe they need to state a certain number to obtain treatment. An intensity rating scale is just the beginning of the assessment process.

Why use pain intensity rating scales? When pain scales are used to screen for pain, the frequency of pain detection improves. Kamel, Phlavan, Malekgoudarzi, Gogel, and Morley (2001) studied methods for assessing pain in 305 long-term care residents. The researchers asked one group about pain with simple questioning and asked the other group about pain using either a visual analog scale, the Faces Pain Scale (FPS), or the Pain Descriptor Scale to rate pain intensity. The frequency of reported pain was significantly greater in the cohort that received a pain rating scale along with questioning (30% versus 15%, $p < 0.01$) (Kamel et al., 2001).

Pain is what the person says it is, occurring whenever the person says it does (McCaffery & Pasero, 1999). Regardless of the person or his or her condition, self-report is the gold standard for pain screening and assessment and should be attempted with all individuals. No test of cognition (e.g., Mini-Mental State Examination) can predict the ability or inability to report pain. Healthcare professionals can make no conclusions based on diagnosis regarding a person's ability to self-report or use a pain intensity rating scale. Cognitively impaired adults who retain verbal ability often are able to self-report current pain (Herr, Coyne, et al., 2006). In a study of older adults with cognitive impairment in long-term care, 83% of those studied could use at least one of five screening tools to self-report current pain (Ferrell, Ferrell, & Rivera, 1995). Although cognitively impaired individuals are not likely to remember their pain levels from previous screenings, many are able to accurately report current pain status.

Iowa Pain Thermometer

- The most intense pain imaginable
- Very severe pain
- Severe pain
- Moderate pain
- Mild pain
- Slight pain
- No pain

Verbal Descriptor Scale

0 None
1 Mild
2 Moderate
3 Severe

Faces Pain Scale–Revised

0–10 Numeric Rating Scale

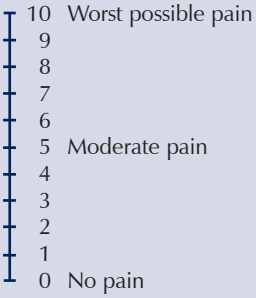

Figure 2. Selected Pain Rating Scales

Note. From "Evaluation of the Iowa Pain Thermometer and Other Selected Pain Intensity Scales in Younger and Older Adult Cohorts Using Controlled Clinical Pain: A Preliminary Study," by K. Herr, K.F. Spratt, L. Garand, & L. Li, 2007, *Pain Medicine, 8,* p. 588. Used with permission from Keela Herr, PhD, RN, College of Nursing, the University of Iowa.

Note. From "Faces Pain Scale–Revised: Toward a Common Metric in Pediatric Pain Measurement," by C.L. Hicks, C.L. Von Baeyer, P.A. Spafford, I. van Korlaar, and B. Goodenough, 2001, *Pain, 93,* p. 176. With instructions and translations as found on the Web site: www.painsourcebook.ca. This figure has been reproduced with permission of the International Association for the Study of Pain® (IASP®). The figure may not be reproduced for any other purpose without permission.

Note. From *Guideline for the Management of Cancer Pain in Adults and Children* (p. 21), by C. Miaskowski, J. Cleary, R. Burney, P. Coyne, R. Finley, R. Foster . . . C. Zahrbock, 2005, Glenview, IL: American Pain Society. Reprinted with permission from the American Pain Society.

Pain is subjective. No diagnostic test can measure pain intensity, and no one can know what pain is like for another person. Reports of pain by family members or healthcare providers do not correlate consistently with pain ratings by the individuals who have the pain (van Herk et al., 2009). When self-report of pain is not possible, clinicians must evaluate and observe patients carefully. Even with sound observations and critical thinking, in the absence of self-report, clinicians are only making educated guesses about the presence or absence of pain. Scores on behavioral pain assessment tools may increase the suspicion that pain is a problem, but the tools measure behavioral changes, not pain intensity.

The most appropriate pain rating scale to use depends on the overall patient population, a patient's preferences and abilities, an individual's past experiences with rating scales, and the documentation system of the setting. Clinicians should consistently use rating scales that are familiar and understood by the individual. Once a preferred scale is identified, it should be documented to enable consistent use across providers and care settings. Examples of reliable and valid pain rating scales for use with cognitively intact and cognitively impaired verbal older adults include the Iowa Pain Thermometer, the Verbal Descriptor Scale (VDS), the FPS–Revised (FPS-R), and the 0–10 numeric rating scale (NRS) (see Figure 2) (Herr, Spratt, Garand, & Li, 2007; Hicks, von Baeyer, Spafford, van Korlaar, & Goodenough, 2001). However, studies comparing various pain scales in cognitively impaired nursing home residents have been inconclusive. Results of one study indicated no difference in pain ratings among the tools studied (Closs, Barr, Briggs, Cash, & Seers, 2004). Another found that the FPS, VDS, and NRS were highly correlated to one another (Jones, Vojir, Hutt, & Fink, 2007). Yet another study concluded that the Iowa Pain Thermometer was preferred by younger and older adults (Herr et al., 2007). According to Herr et al. (2007), older adults, particularly those with cognitive impairment, tend to prefer vertical rather than horizontal scales. Reliable and valid horizontal pain rating scales may be modified to vertical forms for ease of use. Examples can be found on the City of Hope Pain and Palliative Care Resource Center Web site at http://prc.coh.org/pain_assessment.asp.

Adapt published intensity rating scales to the needs of older adults by using large print and easy-to-read fonts (serif fonts such as Times New Roman or Garamond for text and sans serif fonts such as Arial or Helvetica for headings). Covering a tool with nonglare protective film or using orange, yellow, or buff colored paper can help to reduce glare. Use a show-and-tell approach with the scale as a visual cue. Allow sufficient time for responses, especially with patients who are cognitively impaired. Patients should have their hearing aids and glasses on during assessments. Select a quiet location for screening and assessment.

Cognitively impaired adults who are unable to use a pain intensity rating scale may respond to simple questions such as, "Do you have pain or discomfort?" or "Are you hurting anywhere?" These types of questions include language to evaluate different severities of pain and multiple sites. Ask cognitively impaired adults about their pain "now"—not in the past—and document the results in the medical record in a location where it is easy to track over time.

Comprehensive Pain Assessment in Older Adults

Screening a patient for pain with an intensity rating scale is not an assessment. It is only one step in the assessment process. Screening alerts healthcare providers about the presence of pain and later helps them to evaluate whether interventions have had a positive effect. When a person reports pain or pain is suspected in a nonverbal older adult, comprehensive assessment must follow. Figure 3 illustrates an algorithm of domains and categories to include in a comprehensive assessment (Hadjistavropoulos et al., 2007).

All pain management plans must be based on comprehensive assessment information regarding individual responses to pain and to pain relief measures. Assessing pain in older adults is similar to assessing pain in other adults, with some adaptations to account for changes related to aging. A comprehensive assessment includes a physical examination, diagnostics when needed, and detailed questions and observations about an individual's pain, pain relief, the effects of pain on the person, the presence of side effects, additional concerns of the patient and family, and mutually acceptable goals for

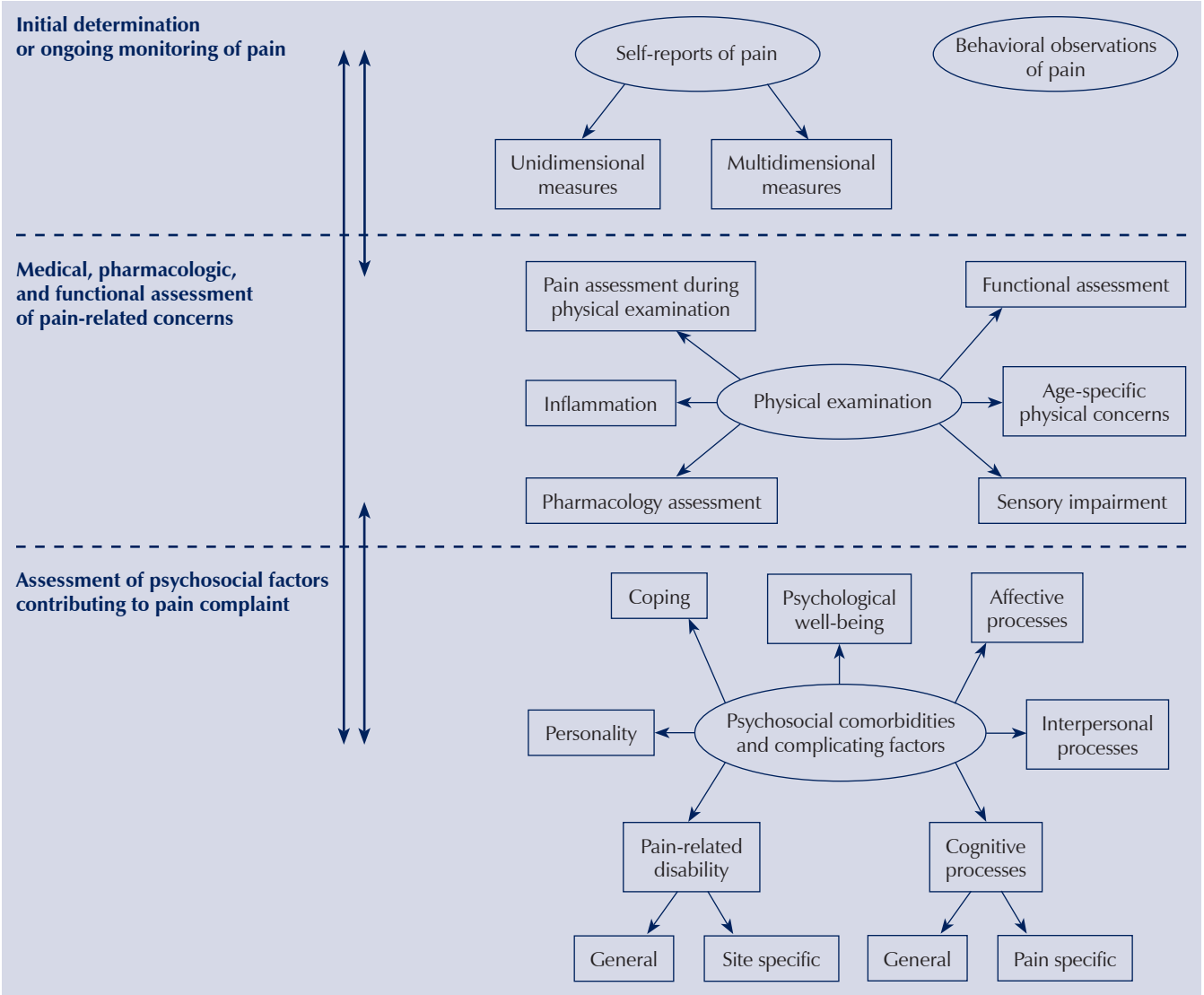

Figure 3. Domains Included in a Comprehensive Pain Assessment

Note. From "An Interdisciplinary Expert Consensus Statement on Assessment of Pain in Older Persons," by T. Hadjistavropoulos, K. Herr, D.C. Turk, P.G. Fine, R.H. Dworkin, R. Helme, . . . J. Williams, 2007, *Clinical Journal of Pain, 23*(1, Suppl.), p. S5. Reprinted with permission from Wolters Kluwer Health/Lippincott Williams and Wilkins.

Pain
- Onset, location(s), duration, quality, severity, and intensity
  - For multiple sites of pain, assess each site separately.
- Presence of persistent or breakthrough pain
- Past experiences with pain and pain relief
- The meaning of pain to the person
- Determine the type of pain and, if possible, the cause.
- Evaluate worst pain now and in the past 24 hours.
- Obtain a pain rating using a valid and reliable rating tool when possible.

Pain Relief
- Responses to current treatments
- Amount of relief achieved, including relief now and best relief obtained in the past 24 hours
- Length of time relief lasts
- Alleviating or exacerbating factors
- Ask about over-the-counter medications, herbs, dietary supplements, and integrative self-care strategies used for relief.
- Obtain a pain-relief rating when possible, using the same scale as for pain ratings.

The Effects of Pain on the Person
- Function, activity, movement, roles, relationships, and sexuality
- Changes in sleep, energy, mood, appetite, behavior, and overall quality of life
- Observe for gait changes, guarding, splinting, self-restriction, or deconditioning.
- Ask about potential barriers to compliance.
  - Cultural preferences and rituals related to pain and pain relief
  - Access to medications (cost, availability, and insurance-related formulary restrictions)
- Inquire about past or present alcohol and drug use for all patients.
- Look for depression, anxiety, and sleep disturbances.
- Complete a psychosocial assessment.

Additional Concerns
- The presence of side effects, including constipation
- Ask whether the patient or family has any concerns about pain or the pain management plan.
  - Address fears of addiction, if present.

Goal Setting
- With the patient, establish a goal for pain relief.
  - Goals may be related to activity, function, a number on a rating scale, etc. Be sure goals are specific, measurable, achievable, and realistic. Include a time frame for reevaluation or completion.
- Schedule times for reassessment based on pain intensity and goals of care.

Figure 4. Comprehensive Assessment

Note. Based on information from Curtiss & McKee, 2004.

pain care. Figure 4 provides details for completing a comprehensive assessment.

Assessing Pain in Nonverbal Older Adults With Cognitive Impairment

Pain is a potential issue in any person with cognitive impairment. Because responses to pain are highly individualized and self-report is the most reliable indicator of pain and pain relief, assessing pain in nonverbal older adults is a challenge. Barriers to assessment include the inability of the person to articulate pain and the presence of inherent affective distress, which often accompanies dementia. Behaviors resulting from other issues can overlap with behaviors associated with pain, and psychotropic agents that often are prescribed to this population can mask pain symptoms. Some clinicians demonstrate desensitization to patients with cognitive impairment, suggesting, "She's always like that," or "He's a hitter or biter," rather than evaluating troublesome behaviors for potential causes such as pain. In addition, clinicians often are reluctant to prescribe opioids to this population. Identifying pain in this population requires vigilance and finely tuned assessment skills.

The hierarchy of pain assessment techniques provides a guide to systematically address pain in cognitively impaired older adults. The following techniques are used in order (McCaffery & Pasero, 1999).

1. Obtain a self-report of pain. If a self-report is not possible:
   a. Search for a potential cause.
   b. Observe patient behaviors.
   c. Obtain surrogate reports (from family members, parents, or caregivers) about pain and behavior and activity changes.
   d. Attempt an analgesic trial.

Obtain a self-report of pain whenever possible. If a self-report is not possible, document the attempts to obtain a self-report and continue to search for potential causes of pain. Consider all of the diagnoses, conditions, and problems, as well as potentially painful procedures such as wound care, rehabilitation activities, cancer treatments, untreated constipation, phlebotomy, and diagnostic tests. If a person has a condition that can potentially cause pain, assume pain is present, document the findings, and develop a plan to treat pain.

In the absence of a known condition that causes pain, watch for subtle changes that differ from the individual's normal behaviors and activities. Differences may be observed in the patient's acceptance of care, belligerence, withdrawal, wandering, swearing, sleep or appetite patterns, activities, posturing (e.g., more rigid, guarding, rocking), fidgeting, chanting, and requests for help, as well as many other possibilities. Observe the person resting and moving. No single set of behaviors indicates pain, and pain behaviors are not always accurate reflections of pain intensity (Herr, Coyne, et al., 2006). Each person's responses to pain are unique.

Minimize the emphasis on physiologic indicators because they do not discriminate between pain and other problems (Herr, Coyne, et al., 2006). Carefully reassess the patient for changes in function, mood, sleep, appetite, or behavior. The better established a patient's baseline activities and behaviors, the easier it is

Table 1. Examples of Common Discomfort Behaviors in Cognitively Impaired Individuals

Variable	Behavior
Body movements	Rigid, tense, guarding, restricted, or bracing Massaging body part or area Fidgeting, rubbing, or clenching fists Increased pacing or rocking Gait or mobility changes
Changes in patterns and routines	Refusing food or having appetite changes Changes in sleep or rest patterns Sudden cessation of normal routines Increased wandering or pacing
Facial expressions	Frowning, sad, or frightened Grimacing or wincing Wrinkled forehead or furrowed brow Clenched teeth and jaw Rapid blinking Any distorted expression
Interpersonal interactions	Aggressive, combative, or resistant Decreased social interactions Disruptive or inappropriate Withdrawn
Mental status changes	Crying or tears Increased confusion Agitated or restless Irritability or distress
Vocalizations	Sighing, moaning, or groaning Crying or whining Grunting, chanting, calling out, or mumbling Asking for help Verbally abusive

to recognize subtle changes that may indicate pain and to differentiate pain from other causes of distress (Herr, Coyne, et al., 2006). Specific pain behaviors should be documented whenever possible.

Table 1 shows common discomfort behaviors in patients who are cognitively impaired. Many behaviors related to the distress of dementia or other health problems are similar to those suggestive of pain. Rule out pain before considering dementia-related psychosis. Tools for evaluating pain in patients who are cognitively impaired are in various stages of development and testing (Herr, Bjoro, & Decker, 2006). Copies of the tools and others, as well as comparisons of the tools to one another, can be found at http://prc.coh.org/elderly.asp.

A behavioral assessment tool measures behavioral changes and provides an index of suspicion regarding the presence of pain. The tools do not measure pain intensity; a rating of 10 on a behavioral tool does not translate to a pain intensity rating of 10. Currently, no one tool is best for assessing pain based on nonverbal indicators (Herr, Bjoro, et al., 2006). A reliable and valid tool that is easy to use and meets the needs of patients, the clinical setting, and the documentation system should be selected and used consistently. Most behavioral tools evaluate the following categories: facial expression, verbalization and vocalization, body movements, changes in interpersonal interactions, changes in activity patterns or routines, and mental status changes. Pain assessment is inferred by physical examination, patient history, and response to treatment. Figure 5 lists commonly available tools, and Figure 6 depicts one of them, the Checklist of Nonverbal Pain Indicators. Detailed critiques and comparisons as well as brief summaries of many tools for assessing pain and behavioral changes in individuals with cognitive impairment are available on the City of Hope Pain and Palliative Care Resource Center Web site at http://prc.coh.org/elderly.asp.

If pain is suspected in a cognitively impaired, nonverbal older adult, be sure that basic needs are met. Evaluate positioning, hunger, thirst, warmth, toileting needs, social contact, the environment, and other requirements for comfort, safety, and quality of life. If pain is a possibility, assume that it is present and develop a plan to treat it. Try nonpharmacologic interventions and attempt an analgesic trial. Treat behavioral symptoms with pain medication before prescribing psychotropic agents (AGS Panel on Persistent Pain in Older Persons, 2002; American Medical Directors Association, 2009). Pain medications have fewer adverse effects, and psychotropic agents may sedate and mask pain—thereby making assessment of changes in behavior or activity more difficult. Responses to an analgesic trial may be diagnostic of the presence of pain. For persistent pain in individuals with cognitive impairment, provide medications on a schedule rather than "as needed."

- Abbey Pain Scale (Abbey et al., 2004)
- Certified Nursing Assistant Pain Assessment Tool (Cervo et al., 2007)
- Checklist of Nonverbal Pain Indicators (Feldt, 2000)
- Disability Distress Assessment Tool (Regnard et al., 2007)
- Discomfort Behavior Scale (Stevenson et al., 2006)
- Doloplus 2 (Holen et al., 2007)
- Elderly Pain Caring Assessment 2 (Morello et al., 2007)
- Mobilization-Observation-Behavior-Intensity-Dementia Pain Scale (Husebo et al., 2007)
- Nursing Assistant–Administered Instrument to Assess Pain in Demented Individuals (Snow et al., 2004)
- Pain Assessment Checklist for Seniors With Limited Ability to Communicate (Fuchs-Lacelle et al., 2008)
- Pain Assessment for the Dementing Elderly (Villanueva et al., 2003)
- Pain Assessment in Advanced Dementia Scale (Warden et al., 2003)
- Pain Assessment in Noncommunicative Elderly Persons (Cohen-Mansfield, 2006)
- Pain Behaviors for Osteoarthritis Instrument for Cognitively Impaired Elders (Tsai et al., 2008)

Figure 5. Pain Tools for Cognitively Impaired Older Adults

Write a "0" if the behavior was not observed and a "1" if the behavior occurred even briefly during activity or rest.

	With Movement	Rest
Vocal complaints: nonverbal Expression of pain, not in words, moans, groans, grunts, cries, gasps, sighs	____	____
Facial grimaces or winces Furrowed brow, narrowed eyes, tightened lips, jaw drop, clenched teeth, distorted expressions	____	____
Bracing Clutching or holding onto side rails, bed, tray table, or affected area during movement	____	____
Restlessness Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still	____	____
Rubbing Massaging affected area	____	____
In addition, record verbal complaints. **Vocal complaints** Words expressing discomfort or pain: "ouch," "that hurts," cursing during movement, or exclamations of protest: "stop," "that's enough"	____	____
Subtotal scores	____	____
Total score	____	____

Figure 6. Checklist of Nonverbal Pain Indicators

Note. From "Checklist of Nonverbal Pain Indicators," by K. Feldt, 2000, *Pain Management Nursing, 1,* pp. 13–21.

Note. From "Treatment of Pain in Cognitively Impaired Versus Cognitively Intact Post Hip-Fractured Elders," by K.S. Feldt, 1996 [doctoral dissertation, University of Minnesota, 1996.] *Dissertation Abstracts International, 57*-09B, 5574. Reprinted with permission from Karen S. Feldt, PhD, ARNP, GNP, associate professor at the Seattle University College of Nursing.

Reassessment

Assessment and reassessment are dynamic and ongoing processes that take place over time. The efficacy of an intervention should be reassessed within the time frame it is expected to show results, and the findings documented. At each follow-up encounter, evaluate the "Four A's" of pain management outcomes: **A**nalgesia, **A**ctivities of daily living, **A**dverse effects, and evidence of **A**berrant behavior (Passik & Weinreb, 2000). Also, evaluate progress toward **A**chieving the goals of care for pain management. Reevaluate the plan of care and reassess for unsatisfactory pain relief, unachievable goals, unacceptable side effects or toxicities, or other concerns. Rating the amount of pain relief on the same scale that was used for pain screening and comparing ratings over time help clinicians evaluate progress. In addition, reporting unrelieved pain with sound assessment data is a powerful tool when advocating for treatment modifications. If patients are taking opioids, in addition to the A's above, reassessment includes asking at each visit, or daily for inpatients, whether patients are having regular and comfortable bowel movements at least every other day. Failure to manage constipation aggressively is one of the most common reasons that patients discontinue or switch their analgesic regimens (Candrilli, Davis, & Iyer, 2009). Document all reassessment findings promptly.

Conclusions

Unrelieved pain in older adults is a major public health problem that can and must be addressed. Pain management is a basic right, and identifying pain in older adults with cancer is a core competency for all healthcare providers. Screening to identify the presence of pain and comprehensively assessing all aspects of pain and its effects on a patient are essential first steps to developing effective pain management strategies. Recognizing pain in cognitively impaired older adults can be a challenge, but this critical task can be guided by published evidence-based guidelines and enhanced by sound assessment skills. To adequately evaluate pain behaviors in patients with persistent pain who have cognitive impairment, clinicians should use reliable and valid published pain screening and pain assessment tools routinely and observe patients carefully. Scheduled reassessments should be conducted regularly to evaluate responses to treatments and the need for revisions in pain management plans. Oncology nurses are in key positions to change systems and advocate for effective pain screening and comprehensive assessment of older adults with pain.

Carol P. Curtiss, MSN, RN-BC, is a clinical nurse specialist consultant and owner of Curtiss Consulting in Greenfield, MA, and an adjunct clinical instructor in the School of Medicine at Tufts University in Boston, MA. Curtiss received honoraria from Endo Pharmaceuticals Inc. for this work. Editorial support was provided by Rebecca Bachmann, PhD. Mention of specific products and opinions related to those products do not indicate or imply endorsement by the *Oncology Nursing Forum* or the Oncology Nursing Society. Curtiss can be reached at carol.curtiss@verizon.net, with copy to editor at ONFEditor@ons.org. (Submitted March 2010. Accepted for publication April 19, 2010.)

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