Pain Assessment Strategies in Older Patients

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Abstract: The prevalence of pain and pain undertreatment in older persons, along with the many potential detrimental consequences of undertreated pain, pose a substantial burden to the individual, their family, and society. An accurate pain assessment is the foundation for treating pain; yet, thorough pain assessments and regular reassessments are too often neglected. Older adults typically present with multiple pain etiologies, making it all the more imperative that a comprehensive assessment is conducted. Comprehensive assessments should include a detailed investigation of a patient’s pain and medical history, a physical examination, and diagnostic testing, if needed. Both the impact of pain and its severity should be established by questioning about the presence of pain and using pain assessment instruments. Tools for pain assessment should be tested in older adult populations to establish reliability, validity, and sensitivity to changes from treatment. Self-report is the gold standard for assessing pain; however, in many clinical circumstances with older adults, the patient’s verbal report is unobtainable. Following an unsuccessful attempt at self-report from a nonverbal older adult, the potential causes of pain should be explored. Direct observation can then be used to identify behaviors suggestive of pain, and the patient’s response to an analgesic trial can be observed. A pain behavior tool can also provide useful information suggesting the presence of pain.

Perspective: A comprehensive assessment of pain in older persons is essential, although more complex and challenging due to comorbidities, sensory and cognitive impairments, and misbeliefs about pain in aging. Best practice recommendations guide approaches and tool selection to facilitate effective pain assessment.

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Key words: Cognitive impairment, pain assessment, pain assessment scales, pain behavior tools, undertreatment.

Persistent Pain in Older Adults: The Importance of Pain Assessment

Persistent pain is common among the aging population, much more so than in younger cohorts. Recent studies on pain found that 17% of adults under 30 in the United States experience pain often compared with 57% of older adults. The prevalence of pain in older persons (typically defined as 65 years or older by demographers, insurers, and employers) consistently demonstrates a substantial burden of pain, with reports of 35% to 48% of older adults in the community experiencing daily pain and 45% to 85% of older persons residing in nursing homes experiencing pain. Furthermore, undertreated pain has many potential detrimental consequences that affect the individual in question but also can burden their family, friends, and even society. These consequences include depression, anxiety, falls, malnutrition, reduced cognition, impaired sleep, functional disturbances, declines in socialization and recreational activities, increased health care costs, and reduced quality of life (QOL). Higher postoperative pain scores are related to longer hospital stays, increased time to ambulation, and chronic functional impairment, indicating that pain has a more potent impact than simply patient discomfort and needs to be addressed early.

An accurate pain assessment is the foundation for treating pain in a systematic way. Yet, a thorough pain assessment and regular reassessments are often...
neglected despite a wide acknowledgment that these are essential components of good pain management. For example, inconsistency in pain assessments was noted in a study of 1454 patients over the age of 65 years who were treated in the emergency department for hip fractures. Thirty-four percent of those studied received no objective assessment of pain, and only 59% were assessed with self-report measures of pain, despite the prevalence of extreme pain (the mean pain intensity score reported was 7/10).° Perhaps consequent to the lack of recognition of pain, 40% of these patients were not prescribed an analgesic.

Self-report is the gold standard for assessing pain; however, in many clinical circumstances with older adults, such as with those who have cognitive impairment, the patient’s verbal report is unobtainable, necessitating use of observer estimates. Available data suggest that clinicians tend to underestimate pain severity, while relatives of a patient perceive greater pain severity than that reported by older adults.°° The adverse consequences of inaccurate estimates of pain include undertreatment or lack of treatment in the first instance, and overtreatment in the second. Thus, attempting to get self-report from the older adult when possible is a priority.

Clinical barriers to appropriate pain assessment that can affect clinicians, caregivers, and any member of a multidisciplinary care team, such as physiotherapists, social workers or pastors, include insufficient training, suboptimal communication methods, and lack of use of appropriate assessment tools.°° Stoic attitudes of individuals in pain, myths about pain being an essential element of aging, and fears about using pharmacotherapies can also hinder the diagnosis and treatment of pain in older adults.°° Misinterpretation and poor detection of pain are particularly problematic in patients with cognitive impairment, as they tend to have memory, language, and speech deficits, and an altered ability to recognize pain.°° Indeed, patients with severe or mixed dementia have a high risk for undertreatment of severe pain.°° This may stem from a diminished ability to describe the characteristics of their pain to health professionals, particularly in the context of home residents identified persistent pain in 49% of those studied.°° Yet, 24% of those with persistent pain received no analgesics, and less than half of the medications were prescribed as standing orders. Acetaminophen was the most frequently prescribed analgesic and often at doses <1300 mg/day.°° A study of the knowledge and beliefs of nurses caring for older adults with dementia in a nursing home setting found that a large number of the professionals thought patients should only receive analgesics “when necessary” rather than on a fixed schedule.°° However, deficits or misbeliefs about the care of older adults can affect all clinicians, not just nurses.

Advanced age is the most important risk factor for developing cognitive impairment,°° and the severity of cognitive impairment has been directly correlated to an increased risk of undertreatment of pain. Furthermore, better cognition has been associated with a greater likelihood of receiving an analgesic other than acetaminophen. In a study of 551 nursing home residents, only 56% of individuals with severe cognitive impairment received pain medications, compared with 80% of the cognitively intact cohort (P < .001) despite a similar rate of pain-related conditions between the groups.°° Notably, cognitively impaired persons were more likely to be given “as needed” pain medications while their peers had regularly scheduled analgesics. “As needed” drug regimens are particularly inappropriate for individuals with moderate-to-severe cognitive impairment who are unable to communicate the presence of pain, much less a need for analgesics.

Components of a Comprehensive Clinical Assessment for Pain

Comprehensive assessment across all populations should include a detailed investigation of a patient’s pain and medical history, a physical examination, and diagnostic testing if needed. Sensory impairments (hearing or vision), dysphasia, aphasia, and cognitive impairments should be noted upfront (potentially through screening with the Mini-Mental State Examination [MMSE]°° or the Mini-Cog°°), as they can impose limitations on the direct information gathered during assessment and diagnosis, or require methods for modifying the techniques used for assessment of pain and its impact. A pain history should include characterization of the current complaint, including associated features or secondary signs and symptoms.°° The present pain complaint should be described in terms of intensity, quality, location(s) (including radiation), pattern (including onset, duration, and frequency), and aggravating and relieving factors.°° Nonverbal cues (eg, guarding, grimacing, and restricted movement) should be noted, particularly if the older person is unable to provide a description of the pain, and furthermore, in circumstances where self-report is unobtainable, gathering information and history from other sources, such as the primary caregiver, can be helpful.°°

One of the main purposes of the history and physical exam is to identify a cause of pain.°° Older adults typically present with multiple pain etiologies. Indeed, a comprehensive assessment is even more critical in this population, in order to gather complete information on all of the locations of pain and the types of conditions that may be causing pain. During history taking, focus should be on known painful conditions that are more prevalent in the aged, with specific attention to the musculoskeletal and nervous systems.°° A proactive approach to pain management includes specific consideration of the most common diagnoses associated with pain in older adults (Table 1). Knowledge of pathological conditions that are common in older adults and known to be painful, such as inflammation, infection (pneumonia, urinary tract infections, skin infections, dental problems),
incisions, fractures, positioning, bladder distention or kidney stones, skin breakdown, ulcers or irritation, gout, peripheral arterial disease, and constipation, can indicate that a person may be experiencing pain. Notably, if a pain etiology can be identified, then treatment can be selected that targets the pathophysiological mechanisms. Discerning between nociceptive and neuropathic pain mechanisms can impact treatment choices.

Common sites of pain and pain referral, especially in musculoskeletal and neurological systems, should be considered. The painful area should be examined for signs of inflammation (redness, edema, elevated temperature) and atrophy (due to disuse). Laboratory and other diagnostic tests can also be useful in establishing a pain diagnosis. However, unless the test is necessary for establishing a diagnosis and guiding treatment decisions, it may not be warranted when considering emotional, physical, and financial costs to the older adult.

Physiologic indicators, such as diaphoresis and increased heart rate, blood pressure, or respiratory rate, can indicate the presence of severe acute pain; however, these measurements are often blunted in the setting of persistent pain and in those with dementia. Also, vital signs can be influenced by medications, diseases, and blood loss. Indeed, identifying a pain etiology may not always be possible, particularly in older adults and especially in those with communication difficulties. Still, persistent pain itself merits treatment.

The impact of pain is a key aspect to consider along with assessing the severity of pain. Toward that end, the patient history should include assessment of QOL and factors that reflect QOL, such as psychosocial functioning, physical functioning, sleep, appetite, mobility, and ability to interact and derive meaning from those activities. Often, QOL indicators and functional measures are the first to improve with treatment (before pain intensity) and, therefore, are often used as outcomes of treatment effectiveness. Hence, it is particularly important to establish a baseline measurement of function. Monitoring for changes in physical, psychological, and social functioning may be used as a proxy for QOL in patients with impaired cognition who cannot report this themselves.

Details regarding factors that ameliorate or provoke pain can influence the tailoring of a treatment plan. Past treatment strategies and the patient’s responses to them, including alternative and homeopathic remedies, should be discussed when taking a patient’s history. Knowledge and attitudes regarding analgesics, as well as openness to trying different treatment approaches, should be investigated. The history of substance abuse (e.g., drug and alcohol) should be considered, as this factor impacts treatment selection and monitoring protocols.

Especially in older adults, comorbidities can impact the experience and expression of pain behaviors and influence selection of the most appropriate treatment approaches. Cognitive impairment, mood disturbances, sleep disorders, and anxiety issues can influence pain perception and presentation. Cardiovascular limitations, renal status, liver function, and gastrointestinal comorbidities are extremely important when conducting a risk-benefit analysis for treatment options. Furthermore, since falls are an important source of morbidity and mortality in older adults, and analgesics as well as pain can increase the risk of falling, mobility and balance are important to assess. A thorough review of an individual’s prescription and over-the-counter medications (including dosage and frequency) and coexisting diseases is an important element of a comprehensive assessment. This enables identification of the potential for drug-drug or drug-disease interactions, as well as any medications that may be exacerbating painful conditions.

### Strategies for Identifying and Measuring Pain Intensity: Self-Report

Self-report is the most accurate, reliable, and well-established method for identifying and characterizing pain. Indeed, 1 study reported observable indicators of pain are present in only half of nursing home residents who have pain. Furthermore, a 2009 study found that the severity and incidence of pain estimated by nurses did not correlate consistently with self-report measurements. Hence, self-report should be attempted and can be attained in the majority of patients even with mild-to-moderate dementia or cognitive impairment. Older adults who have cognitive impairment should be questioned about present pain, and be given repeated instructions and adequate response time.

Determining when older adults with cognitive impairment can no longer reliably report pain on a standard tool can be challenging for clinicians. When there are indications that cognition is worsening, it is recommended to reevaluate for understanding and ability to use a standard pain scale. This can be done by asking the patient to indicate where on the scale a “severe” pain might be and where a “mild” pain might be, and to evaluate the conceptual appropriateness of their responses. The
reliability of responses can be evaluated by having pa-
tients rate their pain on the selected pain scale, distract
them for a few minutes with other activities, and then
ask them to rate this pain again. The scores reported
should be the same if they are reliably reporting current
pain.

When questioning about pain, phrasing has been
found to have an important impact on the information
obtained from older adults.58 Open-ended questions
such as, “Tell me about your pain, aches, soreness, or
discomfort,” typically solicited substantially more pain
information than the closed-ended question, “What
would you rate your pain, aches, soreness, or discomfort
on a 0 to 10 scale, with 0 being no pain, and 10 equal to
the worst pain possible?” Questions biased by social de-
sirability, such as “How are you feeling?” can affect the
answers received, possibly due to patient stoicism and
misconceptions. Older adults often deny the presence
of “pain” but assert feeling “discomfort” or express an-
other similar descriptor.85

Alternative methods of feedback, such as head nods,
hand squeezes, eye movements, or finger-raising can
be used. With culturally diverse patients, tools translated
and validated for that population and/or the presence of
a translator may be required. Individuals with sensory
deficits should be accommodated as needed with en-
larged type, adequate lighting, hearing enhancement,
corrective lenses, and clear and simple instruction in
both verbal and written forms.29

In addition to questioning about the presence of pain,
use of pain assessment instruments increases the fre-
cquency of diagnosing pain in older adults.42 More specif-
ically, nursing home residents administered the Visual
Analog Scale (VAS), Faces Pain Scale (FPS), and Verbal
Descriptor Scale (VDS) had a higher rate of pain report
in comparison to nursing home residents who were only
questioned about the presence of pain.30

The FPS and the FPS-Revised (FPS-R) are alternative
scales for rating pain severity by both younger
American and Hispanic individuals prefer the FPS and
FPS-R, potentially due to the impact of culture on pain
expression.77,84 Notably, the characteristics of the
patient population being treated can impact a decision
regarding the most appropriate pain measure.

The Iowa Pain Thermometer (IPT) is a newer tool orig-
inally developed for research purposes in an effort to in-
crease the ability to capture reports that fall between
numbers or words, thus increasing the sensitivity of
pain detection. With other word-based scales, patients
would often choose more than 1 word, thereby making
their response unclear; the IPT has bubbles between
words to help better capture an individual’s response.38
The IPT was validated through comparison with the
NRS, VDS, FPS, and VAS in a population with arthritis (in-
cluding a cohort with adults aged 65 to 87 years), and
was found to have a comparatively low failure rate
that was not affected by cognitive status.32 Additionally,
the IPT had high sensitivity to change and was the pre-
ferred scale for rating pain severity by both younger
and older adults.32

Tools for pain assessment should be tested in the pop-
ulation of interest to establish reliability, validity, and
sensitivity to change from treatment such as analgesics.27
Also, the administration time and methodology should
Assessing the Impact of Pain on Function and Quality of Life

Assessing the impact of pain on psychological, physical, and cognitive function—and the subsequent effect of that impact on an older adult’s QOL—is an important aspect of a comprehensive assessment. Initial assessment and monitoring for changes can be completed using standard function tools that have been developed and validated specifically for use in older adult populations or by tools developed to specifically address the impact of pain on function. General measures for physical functioning include the Range of Motion (ROM) scale, performance of activities of daily living (ADL), Timed Up and Go test (TUG), Katz ADL Scale, Lawton Instrumental Activities of Daily Living (IADL), and Functional Independence Measure (FIM). The Geriatric Depression Scale (GDS) has been developed to screen for depression in older adults and is easily administered due to its yes/no format; the GDS-15 in particular has been recommended for the diagnosis of depression in primary care settings. Cognitive function in this population can be assessed by either the MMSE or Mini-Cog. The MMSE has been found to be a valid and reliable method for indicating cognitive function in older adults.

A number of tools have been developed for use in older adult populations to specifically measure the impact of pain on QOL components. Two tools of particular interest are the Brief Pain Inventory (BPI) and the Geriatric Pain Measure (GPM). The BPI was originally developed by a pain research group under the auspices of the World Health Organization to measure pain intensity and interference in cancer populations. The BPI is available in multiple forms, including a short form and an adaptation for clinical settings in which the 0 to 10 rating scale, performance of activities of daily living (ADL), and Functional Independence Measure (FIM). The Geriatric Depression Scale (GDS) has been developed to screen for depression in older adults and is easily administered due to its yes/no format; the GDS-15 in particular has been recommended for the diagnosis of depression in primary care settings. Cognitive function in this population can be assessed by either the MMSE or Mini-Cog. The MMSE has been found to be a valid and reliable method for indicating cognitive function in older adults.

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The expression of pain by persons with dementia or cognitive impairment may be altered (Table 2), thereby complicating the interpretation of their behavior by observers. Hence, traditional approaches to pain assessment may fail to effectively identify pain in nonverbal persons with severe dementia.

Indeed, identifying pain in nonverbal individuals involves collecting different kinds of information from several sources, making an initial clinical judgment, and seeking evidence to validate a pain diagnosis. The number and type of pain behaviors presented by individuals with dementia can be variable and vary with the setting and activity level of the patient, thereby making assessment of pain challenging. A hierarchy of techniques for assessing pain in nonverbal patients has been developed and supported in a consensus statement by the American Society for Pain Management Nursing and an interdisciplinary coalition of experts. Even in those with severe cognitive impairment, self-report should be the first method attempted when gathering pain information. Second, potential causes of pain should be explored through a consideration of known acute and persistent painful conditions and diagnoses and recent procedures that may have affected the patient. These pieces of the diagnostic puzzle can be gathered during the history and physical examination. Next, direct observation can be used to identify behaviors, activities, or interactions that may be suggestive of pain. Caregivers, family members, or any person who knows a patient well enough to recognize a change in behavior or pattern of usual activities that might be caused by pain can be a source of this information. Although the presence of pain can be identified through surrogate reports, as supported by its good correlation with patient reports, the accuracy of judgment of pain severity is less strong. Last, if pain is suspected in a nonverbal, older adult, the patient’s response to an analgesic trial can be used as an indicator of the presence of pain. The trial should be initiated with low doses of an analgesic.
Incorporating a pain behavior tool is an important component of a comprehensive pain assessment that can assist in focusing observation and in providing consistent evaluations and monitoring of an individual’s behavior across time and providers. Furthermore, these tools can provide a mechanism for the consistent documentation of assessment and facilitate communication across providers and settings. Also, pain behavior tools can be a key means for evaluating changes in pain behaviors following treatment. Notably though, because judgments of pain severity based on behavior observation do not correlate strongly with self-report of severity, behavioral pain scores are not considered equivalent to a pain intensity rating.

In deciding which pain behavior tool might best serve their population, providers should consider relevance and appropriateness for their particular setting, as well as psychometric properties. Additionally, a tool must have clinical utility, which can be affected, for example, by the time needed for administration, scoring, and training. The outcomes measured by the tool should fit with the quality indicator needs of the population and the institution, as well as the procedures and policies of the organization.

Within the last decade, there have been significant advances in the field of pain behavior assessment tools. Since 2005, 6 review papers have described and critiqued the existing pain behavior tools. Additionally, the City of Hope Web site (http://prc.coh.org/PAIN-NOA.htm; funded by The Mayday Fund) has a detailed and referenced review of English-language tools available for assessing pain in nonverbal older adults based on the most recent studies and current literature. It is a good resource, containing psychometric property details and other characteristics of the individual tools, as well as brief summaries and information regarding the tools and how to access them.

Eighteen tools for assessing pain behaviors in older adults are currently available in English. Many of these tools are promising, and most of them have preliminary reliability and validity, although many require further testing and possibly revision before becoming established diagnostic tools. Several tools have been published internationally and translated to English, but have not yet been tested in English-speaking populations. Continued research to evaluate and refine existing tools is recommended. A list of selected tools available for assessing pain in nonverbal adults is presented in Table 3.

A systematic, multifaceted approach to assessment based on a variety of sources may provide the most accurate judgment regarding the presence of pain. Nonverbal pain behavior tools are one aspect of a comprehensive ongoing pain assessment, but they do not eliminate the need for critical evaluation and decision-making. In combination with other information gathered, these tools can provide insight into whether a nonverbal older adult is experiencing pain. Institutions should establish procedures for assessing pain with behavior tools, including policies on who is responsible for conducting evaluations, as well as when and how often. Implementation of systematic assessments with

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### Table 2. Common Pain Behaviors in Cognitively Impaired Older Adults

<table>
<thead>
<tr>
<th>Behavior Type</th>
<th>Specific Example</th>
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<tbody>
<tr>
<td><strong>Facial expressions</strong></td>
<td>Slight frown; sad, frightened face</td>
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<tr>
<td></td>
<td>Grimacing, wrinkled forehead, closed or tightened eyes</td>
</tr>
<tr>
<td></td>
<td>Any distorted expression</td>
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<tr>
<td></td>
<td>Rapid blinking</td>
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<tr>
<td><strong>Verbalizations, vocalizations</strong></td>
<td>Sighing, moaning, groaning</td>
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<tr>
<td></td>
<td>Grunting, chanting, calling out</td>
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<tr>
<td><strong>Body movements</strong></td>
<td>Rigid, tense body posture, guarding</td>
</tr>
<tr>
<td></td>
<td>Fidgeting</td>
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<tr>
<td></td>
<td>Increased pacing, rocking</td>
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<tr>
<td></td>
<td>Restricted movement</td>
</tr>
<tr>
<td></td>
<td>Gait or mobility changes</td>
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<tr>
<td><strong>Changes in interpersonal interactions</strong></td>
<td>Aggressive, combative, resisting care</td>
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<tr>
<td></td>
<td>Decreased social interactions</td>
</tr>
<tr>
<td></td>
<td>Socially inappropriate, disruptive engagement</td>
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<tr>
<td></td>
<td>Withdrawn</td>
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<tr>
<td><strong>Changes in activity patterns or routines</strong></td>
<td>Refusing food, appetite change</td>
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<tr>
<td></td>
<td>Increase in rest periods</td>
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<tr>
<td></td>
<td>Sleep, rest pattern changes</td>
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<tr>
<td></td>
<td>Sudden cessation of common routines</td>
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<tr>
<td></td>
<td>Increased wandering</td>
</tr>
<tr>
<td><strong>Mental status changes</strong></td>
<td>Crying or tears</td>
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<tr>
<td></td>
<td>Increased confusion</td>
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<tr>
<td></td>
<td>Irritability or distress</td>
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</table>

a pain behavior tool has been found to transition “as needed” dosing to standing orders and, perhaps consequently, to reduce nurse distress and burnout.24 Also, organizations should institute procedures for documenting the outcomes of assessment, defining the location for recording the scored information in order to make it accessible to all the relevant providers, and creating mechanisms for monitoring changes over time.28 In order to monitor and communicate change over time, the data gathered by a tool must be integrated into the documentation system. Periodic evaluations should determine whether the pain assessment processes are being implemented and are indeed fulfilling the goals of the institution in improving quality of pain care.75

Consensus recommendations from an expert group recently supported the Pain Assessment in Advanced Dementia (PAINAD) and Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) for use in assessing pain in nonverbal residents in nursing homes.35 The authors suggest incorporating both tools to assure comprehensive screening for possible pain behaviors and changes in activity, as well as a regular direct observation of selected behaviors commonly noted in this population. The strengths and limitations of both tools are thoroughly considered and presented in the recommendations from the experts of the National Nursing Home Pain Collaborative.25 The PAINAD is a short, simple tool developed to assess pain in a nonverbal population. The PACSLAC is a more comprehensive tool designed for use in assessing pain in nonverbally communicating older adults. Both tools are designed to be used in conjunction with other assessments, such as the Pain Assessment in Advanced Dementia (PAINAD) and Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC).

### Table 3. Tools for Assessing Pain in Nonverbal Older Adults in Nursing Homes Included in the Expert Review and Consensus Building Process

<table>
<thead>
<tr>
<th>TOOL NAME</th>
<th>REFERENCES</th>
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NOTE. Reference listed for each tool is the primary development paper. Readers are referred to http://prc.coh.org/PAIN-NOA.htm for additional psychometric evaluation references.
individuals with dementia. This valid and reliable scale consists of 5 items scored from 0 to 2: breathing, negative vocalization, facial expressions, body language, and consolability.

The PACSLAC is a comprehensive tool consisting of 60 items organized into 4 groups: facial expressions, activity/body movement, social/personality/mood indicators, and physiological indicators/sleeping changes/eating/vocal behavior. Each item is scored as present or absent. The tool covers a broad range of pain behaviors including the categories listed in the American Geriatrics Society guidelines and has been demonstrated to have excellent interrater reliability, strong intrarater reliability, good internal consistency, and clinical usability.

Despite the number of items, the tool can be completed in approximately 5 minutes by a caregiver familiar with its use.

The PAINAD in particular has become very popular because it yields a number on a 0 to 10 scale, has been evaluated in numerous studies in different settings, satisfies credentialing surveyors, and is clinically useable. The utility of the items on breathing and consolability for indicating pain and the ability of the tool to identify pain in those who have less obvious pain indicators remain to be established. However, the internal consistency is not substantially altered by removal of the items in question and modifying any tool hinders cross-study comparisons. Meanwhile, the PACSLAC requires the clinician to document a total score, but the developers do not provide guidance on what a total score means. Regardless of the behavioral tool used, only the presence of pain and whether pain increases or decreases can be assessed for an individual patient; the level of pain intensity cannot be compared across patients.

There are other pain tools that may be more appropriate or easier to use depending on the clinical setting. For example, the Checklist of Nonverbal Pain Indicators (CNPI) is the only behavioral tool that has been tested for assessing acute pain in older adults. It has become quite popular in the hospital setting, although research support remains limited. As noted earlier, there are several well-designed tools from international colleagues, such as the EPCA-2, MOBID, PACSLAC-D, and REPOS, that address some of the limitations of existing tools, but evaluation of their reliability and validity in English-speaking populations are needed before they can be broadly recommended.

Implications for Practice

A comprehensive assessment of pain is critical to identifying pain and creating an optimal treatment plan. Assessment is not a singular event, but rather an ongoing process responsive to the evolving presentation of the older adult. Scales with proven psychometric properties that meet the needs and abilities of the individual being tested should be chosen. Establish a procedure for evaluating the presence of pain and the response to treatment appropriate to the health care setting.

In particular, regular reassessment is often neglected and should be conducted regularly to monitor for improvement or deterioration in pain and function and for complications. Key behaviors that have been observed, as well as outcomes from pain intensity and behavioral tools, should be documented. The same tools used to initially assess pain and/or specific pain-related behaviors should be used for follow-ups. Reassessment using the same methods is necessary to identify progress toward alleviating pain and to determine whether the older person is responding to the treatment plan. At a minimum, function, mental status, mood, and sleep should be monitored. The methods of assessment, as well as the findings of a pain assessment, should be communicated across care providers to facilitate quality pain care as older persons transition between settings of care.

References


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