

Fast Facts on Pain Management

FAST FACTS #8 – ASSESSING PAIN IN THE COGNITIVELY IMPAIRED

Case Study

Mrs. R has been a resident in the same nursing home for three years. When she first was admitted Mrs. R was cooperative, talkative but confused. When she had any discomfort she would rub the affected area and complain of a "hurt". Now Mrs. R is non-verbal and bedbound. She has developed a decubitus ulcer on her coccyx, which requires a daily dressing change. Whenever the nurses try to change the dressing Mrs. R pushes them away. Whenever she is sitting she is often found with her hand behind her trying to pull at the dressing. What might the unusual behaviors of Mrs. R be indicating?

Main Teaching Points:

Recognizing pain in the cognitively impaired can be difficult. Based on observation of new and unusual behaviors, the resident's experience of pain or discomfort can be recognized. Measurable indicators of discomfort can be included on instruments that are easily understood.

Do These	Don't Do These
<ul style="list-style-type: none"> ▪ Use an instrument with simple language, such as the Verbal Descriptor Scale ▪ Use simple descriptors ("aching," "hurting") ▪ Ask "yes/no" questions ▪ Listen for clues in fragmented speech ▪ Palpate areas thought to be painful while asking questions ▪ Assess pain following or during movement ▪ Attempt to assess pain in residents with poor appetite, depressive symptoms, sleep problems, changes of function, agitated behavior, or refusal of care ▪ Observe for furrowed brows, grimaces, groans, and crying out during movement 	<ul style="list-style-type: none"> ▪ Don't use the verbal 1 to 10 scale; it is too complex ▪ Don't discount behaviors as part of dementia ▪ Don't use small-print instruments ▪ Don't interrupt attempts at responses ▪ Don't assume that anti-anxiety medications will relieve pain ▪ Don't forget to ask family members about previous pain complaints of the resident ▪ Don't overlook the possibility of discomfort due to urinary tract infections, constipation, or compression fractures in frail elders ▪ Don't assume that persons with dementia don't experience pain <p>Source: Feldt KS, Improving assessment and treatment of pain in cognitively impaired nursing home residents. <i>Annals of Long-Term Care</i> 2000;8 (9): 36-42.</p>

Recognition of pain in nonverbal or profoundly impaired elders is much more difficult. Observations should be made during movement or palpation of the suspected painful area, when the resident is more likely to perceive pain and cry out. Family reports are important if possible. Look for other indicators such as poor appetite, depressive symptoms, sleep problems, change of function, agitated behavior, refusal of care, moans, groans, or crying.

Observe the resident for three to five minutes, paying particular attention to "unusual" behaviors. It is helpful if you have a form that you can then use to chart and interpret these behaviors. The **Behavioral Observation Scale** is a helpful tool for assessment. **(ON BACK OF THIS SHEET)**

COGNITIVELY IMPAIRED ELDERLY WITH SOME VERBAL SKILLS

A resident's own rating of pain is the most accurate. The Verbal Descriptor Scale is a tool that is strongly recommended for cognitively impaired elders with some verbal skills, especially whose reading skills are preserved (Feldt, 1998). You may want to try other words for pain like "aching," "soreness," "discomfort," "pressure," "burning" (Ferrell, 1995). Be sure that all the resident's basic needs are met before the assessment begins i.e. need to void or change position).

The following instrument may be helpful to recognize pain in the cognitively impaired with some verbal skills.

VERBAL DESCRIPTOR SCALE

_____	5 – PAIN AS BAD AS IT CAN BE
_____	4 – SEVERE PAIN
_____	3 – MODERATE PAIN
_____	2 – MILD PAIN
_____	1 – SLIGHT PAIN
_____	0 – NO PAIN

Remember that recognition of discomfort/pain is the beginning of the assessment.

References:

Feldt KS, Improving assessment and treatment of pain in cognitively impaired nursing home residents. *Annals of Long-Term Care* 2000;8 (9): 36-42.
 Griffie J, Matson S, Muchka S, Weissman D, Improving pain management in long-term care settings: a resource guide for institutional change. Medical College of Wisconsin, 1998.
 Griffie, J., Muchka, S., Weissman, D., Nursing Staff Education Resource Manual: Pain Management 101. The Medical College of Wisconsin, Inc, 2000

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BEHAVIORAL OBSERVATION SCALE

Instructions:

Step 1. The Behavioral Observation Scale will be used for the non-verbal resident with severe cognitive impairment who are unable to understand the rating scale and/or express the presence of pain.

Step 2. Observe the resident for 3 to 5 minutes for behaviors seen. Write '1' if the behavior was observed even briefly during activity or rest and '0' if the behavior was not observed.

Step 3. Obtain the subtotal of the movement scores and at rest scores. Next, total the 2 scores. The Interpretation is as follows: '1-2' mild pain, '3-4' moderate pain, '5-6' severe pain.

CHECKLIST OF NONVERBAL PAIN INDICATORS

Date: _____ Patient Name: _____

(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
1. Vocal Complaints: Nonverbal (Expression of pain, not in words, but moans, groans, grunts, cries, gasps, sighs)	_____	_____
2. Facial Grimaces/Winces (Furrowed brow, narrowed eyes tightened lips, dropped jaw, clenched teeth, distorted expressions)	_____	_____
3. Bracing (Clutching or holding onto siderails, bed, tray table, or affected area during movement)	_____	_____
4. Restlessness (Constant or intermittent shifting of position rocking, intermittent or constant hand motions, inability to keep still)	_____	_____
5. Rubbing (Massaging affected area) (In addition, record verbal complaints)	_____	_____
6. Vocal complaints: Verbal (Words expressing discomfort or pain "ouch", "that hurts", cursing during movement or exclamation of protest "stop", "that's enough")	_____	_____

Subtotal Score _____

Total Score _____

Source: Feldt, KS. Treatment of pain in cognitively impaired versus cognitively intact hpost hip fractured elders. (Doctoral Diss)