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Controlling Pain and Discomfort, Part 1: Assessment in Verbal Older Adults

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Introduction

Pain is a common reason for hospital admission in older adults,¹ and they may experience persistent (chronic) and acute pain simultaneously with episodes of breakthrough pain. Approximately 30% of adults have persistent pain in each age cohort (60-69, 70-79, and 80+),² and due to its high prevalence, pain is an emerging geriatric syndrome.³ However, because nurses and providers in acute and long-term care often find assessment of pain and discomfort in older adults challenging, up to 34% of older adults receive no, infrequent, and/or inconsistent standardized pain assessment.⁴⁻⁵ To increase and improve pain assessment, this first of a three-article series provides recommendations on assessment of pain and discomfort in older adults who can verbally self-report pain.

Pain Assessment by Self-Report in Verbal Older Adults

Assessment and identification of pain is best accomplished through verbal self-report, when possible. Multiple chronic conditions, sensory, communication and cognitive impairments, and mental health issues (Figure 1) increase the risk for/exacerbate pain and complicate pain self-report.⁶⁻⁷ Verbal self-report requires that older adults: are able to identify/interpret painful stimuli, understand and focus on pain question being asked, have a memory of painful event, able to describe pain and assign a numeric score or descriptor to the pain, and be willing to self-report.⁸ In addition to the older adult's self-report, family members may provide additional information about behavior and support for the older adult's pain. A step-by-step guide for pain assessment follows, but this guide should be individualized based on the needs and preferences of the older patient.

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Step 1: Determine older adult's reliability, verbal ability, and willingness to self-report pain

Recommended

Nurses should use their best nursing judgment to determine if an older adult is a reliable health historian by: 1) observing coherency in communication and thought patterns, 2) assessing mental status using a Mini-Cog or Montreal Cognitive Assessment (MoCA) in acute care or Brief Interview for Mental Status (BIMS) for long-term care residents, 3) noting if there is a diagnosis of cognitive impairment while considering that some older adults with mild to moderate dementia are able to self-report, and 4) assessing understanding of pain scales by asking patients to show where no pain or severe pain is represented on a pain scale⁹. Accommodating sensory impairments is important as this could impact ability (Table 1).

In addition to ability, older adults' willingness to report pain is influenced by personal beliefs about bothering nurses, stoicism, ethnic culture, and type of care setting. Some older adults may feel more comfortable reporting pain to the nursing staff with whom rapport has been established. Moreover, various ethnic cultures may require a male or the eldest family member to serve as spokesperson. New or changes in environments may cause acute confusion, making pain assessment more difficult and requiring other techniques, such as the hierarchy of pain assessment⁹ (presented in Part 2 of this series), to accurately determine pain. To encourage self-report, nurses can explain the importance of reporting pain at the onset for best pain control while also encouraging autonomy, dignity, and engagement by expressing to patients, "I'm counting on you to tell me if you are hurting or in any discomfort."

Not Recommended

Reliance on a cognitive impairment diagnosis as a reason for an older adult's inability or unwillingness to self-report pain is inappropriate. Sometimes nurses mistakenly determine pain in older patients, particularly those unable to self-report, merely by observing their body language and facial expressions. However, the only way to establish the absence of pain is to ask about the presence of pain, leading to step 2.

Step 2: Ask older adult if s/he is experiencing pain (or hurting) or discomfort 'right now.'

Recommended

Many older adults may deny pain to the nurse,^{5,7} but may admit to hurting or discomfort rather than pain. Use pain words appropriate for the culture of older adult¹⁰; when there are language barriers use an approved interpreter. If older adult denies pain, a) re-word question and ask if s/he is hurting anywhere¹¹ and b) ask about specific locations that are suspected/expected to be painful.¹²

Not Recommended

The phrasing of questions is very important in order to prevent socially-biased answers or responses about overall well-being not specific to pain. For example, *when specifically assessing pain*, refrain from asking: “You're not in any pain are you?”, “How are you feeling today?”, or “Are you comfortable?”

Step 3: Measure pain intensity using a valid, reliable, and preferred pain scale**Recommended**

Intensity can be measured using a self-report pain scale such as a Verbal Descriptor Scale (VDS), verbal numeric rating scale (NRS, vNRS, or VNS; <http://www.geriatricpain.org/Content/Assessment/Intact/Pages/default.aspx>), Faces Pain Scale-revised (FPS-r; <http://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1519>), or Iowa Pain Thermometer (IPT or IPT-revised). Have various scales in different languages available, introduce and explain how to use each scale, determine which scale meets their sensory and cognitive needs and is preferred by the patient, and use the same scale throughout their care. Research indicates that older African and Hispanic Americans prefer the FPS-r, IPT-r, VDS; Asian Americans the NRS; and Caucasian Americans the NRS, VDS, and IPT.¹³⁻¹⁵ The NRS should not be used alone, particularly in advanced age when the ability to appropriately use the NRS decreases; rather a combination of scales such as the VDS with the NRS is recommended.¹⁶⁻¹⁷

Not Recommended

The Wong-Baker FACES is not encouraged in older adults because it was originally developed for children, uses happy faces rather than neutral expressions such as those used in the FPS-r, displays tears on faces which could be problematic in getting older men or patients who are more stoic to use the full scale, and the animated cartoonish faces are less appealing to adults (personal correspondence with Dr. Keela Herr, 2014). The visual analog scale (VAS) is also not recommended because it is more difficult for older adults to use accurately.¹⁴

Step 4: Assess the tolerability of pain**Recommended**

Pain tolerability involves assessing how bearable/bothersome and disabling pain is in relation to functional ability. One-third of older adults reported postoperative pain as “painful but bearable” with a NRS of 5/10,¹⁷ while nearly 53% of older adults have reported bothersome pain.¹⁸ Older adults may state, “I can stand the pain, it's not that bad,” then refuse pain medications.^{19(p.805)} When pain medication is refused, offer non-pharmacological interventions and continue frequent assessments. Moreover, persons with chronic pain have a different reference point in regards to pain intensity and tolerability of pain. For example, an intensity rating of 5/10 for chronic pain may be different than an

intensity rating of 5/10 for acute pain; a patient with chronic pain may consider 5/10 more bearable warranting a different set of treatment options.

It is important to ascertain impact on function since this could limit rehabilitation activities (e.g., ambulation, incentive spirometry, basic and instrumental activities of daily living) and ability to re-integrate into the community. The functional pain scale can be used to assess how pain impacts function.²⁰ Ask about pain during rest and movement, particularly if you suspect the patient has pain when moving or is worse with movement. Provide pain treatments prior to painful activities such as rehabilitation.

Not Recommended

Do not assume that pain reported as “bearable” should not be treated in some way. Thoughtfully explain the effects of unrelieved and under-treated pain, and dispel any misconceptions or fears related to pain treatment. If pain is severe, bed rest for 24 hours only with regular turning/re-positioning may be an option, given that longer periods of bed rest results in loss of muscle strength and mass, skin breakdown, overall deconditioning, and pneumonia.²¹ At a minimum, treat pain, reposition patient often, and perform range of motion exercises.

Step 5 Assess the impact of pain on sleep and mood

Recommended

Patients should be asked about the impact of pain on sleep and mood. Prior to older adult falling asleep for the night, assess pain and develop an overnight pain assessment and management plan (i.e., awakened for assessment and treated for pain considering that breakthrough pain is likely to occur during the night). Awaken the patient to assess pain if they are receiving around the clock pain medication.

Pain may contribute to depressive symptoms, anxiety, or anger. These emotional states make assessment and treatment more challenging and pain more intense. The Patient Health Questionnaire (PHQ-9, PHQ-2), or geriatric depression scale (GDS) can be used to assess depression in long-term or acute care.²²

Not Recommended

Assuming that an older adult who is asleep or sedated is not experiencing pain is inaccurate. Remember that sedation (in critical care units) does not eliminate pain, and patients under sedation are more vulnerable to pain and at risk for under-assessment.²³

Step 6 Mutually develop a pain management plan with comfort-function-mood goals

Recommended

After assessment, discuss appropriate options with the patient and family, and with an interdisciplinary team develop a pain management plan incorporating both non-pharmacologic (complementary/alternative) and pharmacologic treatments. During this

discussion, create measureable and attainable comfort-function-mood goals to improve or maintain pain comfort level, function, and mood. Plans for pain management should be noted in the patient's health record and any advanced directives and shared with all providers during all care transitions.

Not Recommended

The patients' plan of care should not be developed by the nurse or physician alone. Patients should be reminded that no (i.e., zero) pain is not always a realistic goal, rather patient-determined meaningful reductions in pain are more appropriate.

Conclusion

Adequate pain management is a human right and moral imperative for all patients, but especially for the older adults considering the prevalence and evidence showing significant under-assessment.^{2,5,9} In performing an assessment, nurses are able to develop patient-centered care plans that can reduce and/or prevent escalation of pain. Applying the recommendations outlined in this article will equip nurses to prevent the pain cascade (e.g., escalation of pain intensity, distress, and development of breakthrough pain), minimize potential suffering, and maximize quality of life.

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Figure 1.
Pain Web of Contributing Factors

Table 1

Sensory Impairments in Pain Management

Sensory Impairment	Associated Pain/Discomfort Condition	Effects	Solutions for Accommodating for Impairment
Hearing	<ul style="list-style-type: none"> ■ Ear infection or impaction ■ Poorly fitting hearing aids 	<ul style="list-style-type: none"> ✗ May not hear pain questions being asked 	<ul style="list-style-type: none"> ✓ Reduce extraneous noise ✓ Speak facing the patient with a steady pace ✓ Speak clearly and audibly using a low to moderate tone ✓ Ensure hearing aids and amplifiers are in place and working properly. ✓ Use sign-language interpreter for those who are deaf— know that certain pain descriptors are not available in American Sign Language (ASL) ✓ Use a visual pain scale with written instructions ✓ Assess cerumen (ear wax) impactions
Vision	<ul style="list-style-type: none"> ■ Increased intraocular pressure ■ Eye infection ■ Dry eyes 	<ul style="list-style-type: none"> ✗ Unable to view pain scales such as the FPS and IPT, although these are the preferred and recommended tools for older adults ✗ Unable to read pain education instructions or pain medication bottles 	<ul style="list-style-type: none"> ✓ Encourage use of eyeglasses (be aware of outdated eyeglass prescription) ✓ Use a magnification device ✓ Large font ✓ Bold text ✓ Contrasting and dark colors ✓ Non-glare printing material ✓ Adequate lighting ✓ Use a verbally-administered pain tool, but verify understanding in those with cognitive impairment ✓ Always tell patients what kind of medications they are receiving
Taste (and oral cavity)	<ul style="list-style-type: none"> ■ Oral sores from periodontal disease ■ Irritated gums from poorly fitting dentures ■ Burning mouth syndrome 	<ul style="list-style-type: none"> ✗ May decrease appetite and limit older adults' willingness to take anything by mouth ✗ Refuse to take unpleasant-tasting pain medication ✗ Decreased nutritional intake, possibly leading to anorexia ✗ Oral pain and sores may limit medication and food intake 	<ul style="list-style-type: none"> ✓ Ask for a flavored, liquid preparation ✓ Combine medications with food if not contraindicated ✓ Be aware of swallowing difficulties ✓ Medications should be dosed according to weight ✓ Consider other routes if swallowing is impaired: parental, rectal, topical, or transdermal
Touch (and skin)	<ul style="list-style-type: none"> ■ Fibromyalgia ■ Neuropathies ■ Pressure ulcers ■ Skin tears ■ Injections, intravenous insertions/blood draws, and blood glucose sticks ■ Incontinence rashes ■ Calluses 	<ul style="list-style-type: none"> ✗ May be sensitive to touch ✗ Reduced pain-touch sensation, particularly with neuropathies ✗ May not prefer therapeutic touch as a pain intervention 	<ul style="list-style-type: none"> ✓ Ask patients for permission to touch ✓ Be aware that transdermal absorption of analgesic may be altered in older adults with thin skin ✓ May be more sensitive to warm-cool therapies for pain treatment ✓ Fall precautions in place for those unable to sense feet on floor