

Assessing Pain in the Patient with Impaired Communication: A Consensus Statement from the VHA National Pain Management Strategy Coordinating Committee

Abstract

Patients with difficulty in communication due to problems such as cognitive impairment can suffer pain and need to be assessed. There is a relative lack of established, reliable and valid measures for assessment of pain in these patients. Clinicians should first seek to develop some form of patient self-report using the various validated pain intensity measures available. Examples of these measures are available in the [Pain as the 5th Vital Sign Toolkit](#) and the [Pain Outcomes Toolkit](#) on the Department of Veterans Affairs Pain Website (http://www1.va.gov/Pain_Management/page.cfm?pg=2). Only this patient self-report data should be entered into the Pain Vital Signs section of the Computerized Patient Electronic Record (CPRS). When no patient self-report can be obtained, clinicians should tailor the assessment to the patient. Assessment should be done in a structured fashion using consistent sources of information repeatedly over time. Sources of information include reports from significant others, staff observations of patient behaviors in movement and at rest, and empirical trials of pain interventions. These assessments should be documented in a Progress Note in CPRS.

Assessment of Pain in the Communication-Impaired Patient

The assessment of pain in the communication-impaired patient such as those with severe cognitive impairment represents one of the most significant challenges in the field of pain management (Weiner & Herr, 2002). Caregivers have difficulty knowing when these patients are in pain and when they are experiencing pain relief. This makes the patient vulnerable to both under-treatment and over-treatment. Persons with severe cognitive impairment tend to report fewer complaints (Parmalee, 1996). Failure to report pain should not be assumed to mean the absence of pain.

The practitioner should realize that the most accurate data for assessing pain is obtained in the following order:

1. Patient's report of pain
2. Reports of patient's pain by family or friends
3. Patient's behaviors
4. Physiological parameters – most useful in acute pain

Patient's Self Report of Pain

Pain is a subjective experience. A patient's self-report of pain and pain intensity is the best source of information. Clinicians should avoid relying on their own judgment to estimate a patient's pain. Effort should be directed toward seeing if a patient can use some form of self-report. This requires that the patient be able to communicate the existence of pain through vocal or non-vocal communication and to rate the intensity of the pain. Several studies have demonstrated that elderly patients with mild to moderate cognitive impairment can respond reliably to measures of pain intensity (Chibnall, 2001; Weiner, et al., 1998; Ferrell, et al., 1995).

Assessment reliability can be increased by referencing pain questions in the here and now and using the same scale repeatedly over time with a patient. The patient's ability to use self-report scales can improve with practice. It is worthwhile to spend time repeatedly educating the patient in order to get the best assessment. The clinician should focus the assessment question in order to get the most accurate results. It is helpful to ask the patient "how much pain are you having right now" versus "how much pain have you had over the last week or month". The latter questions require additional integration of information and demand more cognitive ability (Ferrell, 2000).

Self-report can also be improved by other strategies. Clinicians should inquire about the patient's definition of pain to determine to what extent the patient perceives pain as a sensory, emotional, and behavioral event. This will help the clinician in educating the patient about the use of the self-report tool and aid in the interpretation of the patient's response. It is helpful to develop a shared understanding of pain intensity with the patient by asking him or her to describe painful events that have been experienced that correspond to different pain intensities. Patients can be prompted by asking about common events that occur in a clinical setting such as needle sticks.

Only patient self-report of pain intensity should be entered into the Vitals Sign Package of CPRS. This ensures that all pain data entered into the Vital Signs Package comes from the same measurement source. The data cannot be analyzed reliably if this practice is not followed.

Observation of Behaviors to Assess Pain

When a patient is unable to use a self-report method despite efforts toward education, assessment must rely on observation of behaviors. Family members or consistent caregivers can provide valuable insight into the patient's usual behaviors and changes in behaviors that might indicate the presence of pain (Weiner & Herr, 2002).

Some common pain behaviors in cognitively impaired older persons have been identified (AGS, 2002; Herr & Garand, 2001). These include facial expressions, verbalizations or vocalizations, body movements, changes in interpersonal interactions, changes in activity patterns or routines, and mental status changes. But some patients with cognitive impairment exhibit little or no specific behaviors associated with pain (AGS, 2002; Asplund, Norberg, Adolfsson et al., 1991). These pain behaviors have not been systematically evaluated in younger patients with cognitive impairments.

Pain behaviors should be observed and assessed both at rest and during movement (Feldt, 2000; Feldt, Ryden, & Miles, 1998; Hadjistavropoulos et al., 2000; Weiner, Pieper, McConnell, Martinez, & Keefe, 1996). Weiner and Herr (2002) and others have noted that it is important to consider other causes of behaviors when relying on observation to assess pain. It is important to consider these other potential causes of distress behavior so that analgesic treatment does not mask problems such as infections, constipation, bladder problems and primary mood disorders.

Empirical Trials of Analgesics

Empirical trials of analgesic medication can be used as part of a pain assessment. This should be done in conjunction with other methods of assessment to evaluate the hypothesis that the behaviors are indicative of significant pain (Baker, Bowring, Brignell, & Kafford, 1996; Kovach, Weissman, Griffie, Matson, & Muchka, 1999). This should not be a first line method of assessment. There are no tested protocols for this practice. It is very important to consider other potential causes of distress behaviors or agitation that could be masked or worsened by analgesics. Many analgesics can negatively alter cognitive status and this should be considered during the course of a trial. Changes in function and activity as well as other pain behaviors should always be assessed in the context of an analgesic trial. Observational data should be entered as a progress note in CPRS.

Tools for Assessment of Pain in Cognitively Impaired Patients

There are a number of devices and protocols that have been developed to aid in the assessment of patients who have impaired communication due to failures in cognition. These devices are based on observation of behaviors. Most of the available instruments have been developed for use with elderly patients. All the tools currently available suffer from a lack of studies to determine adequate reliability and validity. Clinicians should be very cautious about using an instrument that does not have established reliability and validity even if it appears to have face value (Herr, et. al, 2002).

Some instruments provide a pain score. This score should not be treated as a patient's self-report of pain intensity. Pain scores derived from clinical observation tools should be documented in a progress note in CPRS. *These scores should not be entered in the Vital Signs section of the record.*

Pain assessment has not been studied in other adult groups with risk for cognitive impairment such as the developmentally disabled and persons with traumatic brain injury (Schwartz, 1999; Bryant et al, 1999). In the absence of data with other groups, strategies that have proven to have utility with cognitively impaired elders provide a starting point for use with these populations.

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