Assessing Pain in Persons with Dementia

Ann L. Horgas, RN PhD

WHY: There is no evidence that persons with dementia physiologically experience less pain than do other older adults. Rather than being less sensitive to pain, cognitively-impaired elders may fail to interpret sensations as painful, are often less able to recall their pain, and may not be able to verbally communicate it to their care providers. As such, cognitively impaired older adults are often under-treated for pain (Horgas & Tsai, 1998).

As with all older adults, those with dementia are at risk for multiple sources and types of pain, including chronic pain from conditions such as osteoarthritis and acute pain. Untreated pain in cognitively impaired older adults can delay healing, disturb sleep and activity patterns, reduce functioning, reduce quality of life, and prolong hospitalization.

TARGET POPULATION: Older patients who, because of cognitive impairments, may not be able to be assessed for pain using standardized pain assessment instruments. Thus, beginning with the individual’s reentrance into the hospital, whether through planned or emergent entry, interpreting behaviors and assessing pain is essential.

BEST TOOLS: Currently, there are few valid and reliable tools available specifically to measure pain in older adults with dementia. We recommend the following:

- Use a standardized tool to assess pain, if possible. Many persons with dementia can respond to pain measures such as the Verbal Descriptor Scale (Herr, 2002; see also Try This on pain assessment). This tool measures pain intensity by asking participants to select a word that best describes their present pain (e.g., no pain to worst pain imaginable). This measure has been found to be a reliable and valid measure of pain intensity, and is reported to be the easiest to complete and the most preferred by older adults (Herr & Mobily, 1993).

- Use an observational tool to measure the presence of pain in persons with dementia. The Checklist for Nonverbal Pain Behaviors (Feldt, 2000) is designed to assess pain behaviors in post-operative patients. This measure has high inter-rater reliability (93% agreement; Kappa = .63 to .82) and is positively associated with self-reports of pain. The presence of a pain indicator is scored as a 1, and the total number of indicators are summed for those occurring at rest, with movement, and overall. The relationship between scores on this tool and pain intensity ratings has not yet been established; i.e., there are no clear cutoff scores to indicate pain severity. Instead, the presence of any of the behavioral indicators listed may be indicative of pain, and warrants further investigation, treatment, and monitoring by the practitioner.

- Ask family or usual caregivers as to whether the patient’s current behavior (i.e. crying out, restlessness) is different from their customary behavior. This change in behavior may signal pain.

- If pain is suspected, consider a time-limited trial of a mild analgesic agent, such as acetaminophen. Thoroughly investigate behavior changes in persons with dementia and, once other causes have been ruled out, initiate a trial of analgesic. Observe closely for changes in expression, behavior, and movement consistent with alleviation of pain (Kovach et al., 1999; Weiner & Hanlon, 2001).

STRENGTHS and LIMITATIONS: Pain is a subjective experience and there are no definitive, universal tests for pain. For patients with dementia, it is particularly important to know the patient and to consult with family and close contacts.

BARRIERS to PAIN MANAGEMENT in PERSONS with DEMENTIA: There are many barriers to effective pain management in this population. Some common myths are:

(a) pain is a normal part of aging
(b) if a person doesn’t say they have pain, they must not be experiencing it, and
(c) that strong analgesics (e.g., opioids) must be avoided in elderly.

A more effective approach to pain management in persons with dementia is to assume that they do have pain if they have conditions and/or medical procedures that are typically associated with pain. That is, take a proactive approach in listening and observing for pain and take steps to alleviate it.
References


Date: ________________________  Patient ID: _____________________________  Hospital Day ___________________________

**Checklist of Nonverbal Pain Indicators**

*(Write a 0 if the behavior was not observed, and a 1 if the behavior occurred even briefly during activity or rest.)*

<table>
<thead>
<tr>
<th></th>
<th>With Movement</th>
<th>Rest</th>
</tr>
</thead>
</table>
| 1. Vocal complaints: Non-verbal  
(Expression of pain, not in words, moans, groans, grunts, cries, gasps, sighs) |   |      |
| 2. Facial Grimaces/Winces  
(Furrowed brow, narrowed eyes, tightened lips, jaw drop, clenched teeth, distorted expressions). |   |      |
| 3. Bracing (Clutching or holding onto side rails, 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 exclamations of protest (e.g., stop; that’s enough)) |   |      |

Subtotal Scores

Total Score
