Tools to examine strategies that promote effective recognition, assessment, and treatment of pain in older adults including those living with dementia.

- Pain Management Process Indicator
- Education
  - Pain Management Fact Sheet
  - Antipsychotic Alternatives (TMF tool)
- Validated Geriatric Pain Scales
  - Numeric Rating Scale
  - Faces Pain Scale
  - Verbal Descriptor Scale
  - Pain Assessment in Advanced Dementia Scale (PAINAD)
- Tools and Resources
  - CNA Pain Recognition Tool
  - Pain Management Communication Sheet
  - Onset, Peak & Duration of Common Pain Medications Table
  - MDS Section J: Pain Assessment Interview
PAIN MANAGEMENT PROCESS INDICATOR

SETTING UP YOUR SYSTEM

Objective
Assist homes to provide a standardize process in which to maintain effective pain recognition. According to F309 effective pain recognition and management requires an ongoing facility-wide commitment to resident comfort, to identifying and addressing barriers to managing pain, and to addressing any misconceptions that residents, families, and staff may have about managing pain.

Team Members and Duties

- **DON OR DESIGNEE**
  - Monitor process
  - Provide clinical judgement for assessment and treatment choices
  - Monitor regulatory compliance

- **MDS COORDINATOR**
  - Provide QM report information: who is triggering, facility observed percent for measure
  - Monitor progress towards goal
  - Provide MDS schedule information
  - Update care plan during meeting

- **MD/APN/DESIGNEE**
  - Provide clinical judgement for assessment and treatment choice

- **CHARGE NURSE/UNIT MANAGER/RN SUPERVISOR**
  - Process owner for the process improvement project
  - Provide information about resident condition and response to treatment
  - Ensure meetings occur
  - Develop and follow agenda
  - Keep minutes
  - Communication liaison with staff
  - Provide staff education regarding pain management
  - Provide reeducation opportunities when concerns are noted

- **CNA**
  - Provide information about resident condition and response to treatment
  - Provide pain management communication to and from staff members closes to residents
  - Time keeper for meetings

- **PT/OT**
  - Treatment input
1. **Implement systematic process for comprehensive assessment upon admission/ readmission and at regular intervals.**
   - Utilize a comprehensive assessment which includes:
     - resident and family’s pain goals
     - pain related diagnoses
     - current pain status – pain intensity, location of the pain
     - cognitive status
     - pain history including:
       - type of pain,
       - onset of pain,
       - location of pain,
       - frequency of pain,
       - intensity/severity of pain,
       - description of pain,
       - pattern of pain,
       - aggravating factors,
       - alleviating factors,
     - effects of pain on life (sleep, appetite, physical activity, emotions, mood, nausea),
     - response to current treatment and plan for addressing pain.
   - Assess resident pain within 24 hours of admission/readmission and at regularly determined intervals.

2. **Develop and implement a care plan for each resident found to have pain.**
   - Plan of care should include:
     - Pain control goal
     - If pain is daily, consider providing medication on a regular schedule (e.g. around the clock), not just PRN?
     - Provide for medication use by mouth if at all possible
     - Provide for using non-pharmacological approaches to pain management (e.g. massages, topical analgesics, music, aromatherapy, ice or heat, etc.)
     - Address positioning and proper movement to minimize pain
     - Follow current clinical standards of practice for pain management

3. **Monitor pain on a regular basis.**
   - Consistently utilize a standard pain scale for measuring pain every shift
   - Consistently provide pain relief interventions at optimal intervals

4. **Reassess effectiveness of pain intervention and revise as needed.**
   - The MDS 3.0 pain interview may be utilized prior to MDS ARD to assess effectiveness of current care plan interventions. If resident indicates pain is not well controlled revise care plan interventions.
5. Develop systematic approach to pain assessment and management.
   - A weekly QI meeting provides best opportunity to maintain systemic approach to pain management.

6. Develop program for initial and ongoing education on pain assessment and management for both nursing and non-nursing staff.

7. Provide education for residents and family regarding pain management

PAIN MEETING SAMPLE AGENDA

- Review residents currently on pain management program

- Review Residents (suggestions):
  - All newly admitted / readmitted residents (within 24 hours of admission)
  - All residents triggering on QM report,
  - A portion of total census:
    - To ensure all residents in facility have pain appropriately assessed and monitored,
    - Consider dividing remaining census by four and discussing a certain number each week.
    - (for example census =60; 60/4 = 15. Plan to discuss 15 residents each meeting)
  - Review residents whose MDS will be due in 2 weeks or more.

- Review chart for pain indications and triggers – such as wound dressing, recent surgery, diagnosis that indicate pain; history of pain; etc.

- Review current pain interventions determine whether they are given, assess effectiveness of current regimen. MDS 3.0 pain interview may be utilized to ask the resident

- Review documentation – note trends in pain onset and relief

- Develop interventions- i.e. routine order vs prn; nonmedical interventions; increase dosages, etc.

- Communicate residents who need pain monitoring and interventions to staff
SAMPLE QUESTIONS FOR SYSTEM AUDIT:

These six questions represent significant issues in the overall pain management program. The questions follow pain management quality processes that are evidence based. These questions can be used to audit the pain management quality improvement program for your center.

1. **Was an appropriate, comprehensive, and timely pain assessment completed for this resident within 24 hours of admission?**
   (Definition: Using a pain assessment tool that is appropriate to the resident’s condition and cognitive status that includes pain history, type of pain, location, intensity, diagnosis/cause, and pain management goal)

2. **Was an appropriate, comprehensive, and timely pain assessment for this resident completed upon a significant change of condition that affected the resident’s pain?**
   (Definition: Using a pain assessment tool that is appropriate to the resident’s condition and cognitive status that includes pain history, type of pain, location, intensity, diagnosis/cause, and pain management goal)

3. **Is there an individualized pain goal and treatment plan identified for this resident and documented in the care plan? Has family/representative been included in developing plan of care?**
   (Definition: addresses personal pain goals, and interventions/strategies to address the effects of the pain, to alleviate aggravating factors, to support alleviating factors, and to address drug side effects.)

4. **Is the resident’s analgesic or treatment side effects assessed, addressed and documented if they have them?**

5. **Did residents have their moderate to severe pain treated appropriately?**
   (If the pain was severe, did nurse choose the medication ordered for moderate to severe pain)

6. **Was there a reassessment of resident’s pain following treatment / intervention?**
   (Definition: within 1 hour of analgesic administration.)
Pain Management
What all nursing home residents and families need to know

What is Pain?
Pain is a sign of some physical hurt or disorder. Pain is the way your body tells you that something is wrong, but you can be in pain even when no actual harm is being done to your body.

People experience pain differently. The amount of pain a person has depends on the type of pain it is, where it is located, and how sensitive the person is to pain. A person with a lower tolerance of pain feels it faster or more intensely than someone else who has a higher tolerance for pain. Feeling scared or anxious can make the pain feel worse.

If you are in pain, it is up to you to judge how much pain you are in. Your doctor and nurse can help you choose a way to manage pain that is right for you.

Non-drug Pain Relief
There are several ways to manage your pain without taking medicine. These can be used alone, or together at the same time:
- meditation
- imagery
- relaxation techniques
- music
- nerve stimulation
- humor
- heat or cold
- distraction
- aroma therapy
- exercises
- therapeutic activities
- massage

Medications for Pain
Different types of medicine control pain. They range from over-the-counter aspirin to prescribed narcotics.

Medical studies show that it is better to take pain medicine before pain gets too severe. Otherwise, you may have to take more pain medicine to relieve it later. In fact, when you take pain medicine on an around-the-clock schedule, you use less of it. This will help you better control your pain.

Concerns about Pain Medication
Addiction
When you take pain medicine to control pain, it doesn’t mean you are addicted. It is unlikely that someone in pain will become addicted to pain medicine no matter how much or how often they take it. Addiction is psychological as well as physical.

Physical Dependence
Physical dependence is not addiction. Dependence can occur when you take narcotics over a long period of time. If you no longer need pain medicine, your doctor will slowly decrease the amount over a few days to help your body adjust.

Tolerance
Tolerance means your body may need more pain medicine to control your pain. Tolerance may occur when you take pain medicine over a long period of time. This is normal and can be managed by your doctor and nurse.
What about Side Effects?
Pain medicine can cause side effects that happen when you first start taking pain medicine, and usually wear off after a short period of time. It is important to be aware of the side effects, so that you can report them to your nurse or doctor. Information about common side effects is provided below.

Constipation
This common side effect occurs because pain medicine can slow down the function of your intestines. Constipation can be prevented by drinking adequate fluids, eating foods high in fiber like grains, fruits and vegetables, staying physically active, and taking stool softeners or laxatives as directed by your physician.

Drowsiness
Narcotics cause this side effect. It usually disappears in a few days, when your body has adjusted to the pain medicine.

Nausea
Several things can cause this side effect, including pain medicine, pain itself, anxiety, other medications, or constipation. You can help control nausea by:
- Eating small amounts often and slowly
- Avoiding fatty or fried foods
- Using a straw to drink
- Resting after meals

Dry Mouth
Dry mouth is another side effect of pain medicine. Rinsing your mouth and drinking plenty of fluids will make your dry mouth feel better.

Describe Your Pain
There are two categories of pain:
1. Acute pain usually has a definite onset and does not last a long time. It usually feels better as the injury heals.
2. Chronic pain lasts for longer periods of time, such as arthritis, back pain, or cancer pain.

It is very important to tell your doctor or nurse everything you can about your pain so they can help you relieve it. When you are asked to describe your pain consider the following questions.

- When did the pain begin?
- What does the pain feel like (sharp, dull, throbbing)?
- Where is the pain?
- What type of pain is it (constant or off and on)?
- What makes the pain worse (walking, coughing, moving, etc.)?
- What does the pain prevent you from doing (sleeping, eating, socializing, etc.)?
- What relieves your pain?
- How severe is your pain?
Antipsychotic Alternatives

The following information suggests ideas for reducing antipsychotic drug use. A carefully monitored use of the alternatives with frequent reassessment is suggested. Always start by assessing the resident for pain*

General Principles

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident’s life story. Help the resident create a memory box.
- Play to the resident’s strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.*
- Provide consistent caregivers.
- Screen for depression & possible interventions.
- Reduce noise (paging, alarms, TV’s, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

What to try when the resident resists care

Therapeutic Intervention

- Evaluate recent medication changes, especially if the behavior is new.
- Determine if the resident is in pain, and if so, why? Treat the pain.*
- Evaluate whether the care can be performed at a different time.
- Determine if the resident is trying to communicate a specific need.
- Evaluate the resident’s sleep patterns.
- Place the resident in bed when he or she is fatigued.
- Evaluate if there has been a change in the resident’s routine.
- Provide a positive distraction, or something the resident enjoys.
- Is the resident hungry? Offer the resident a snack prior to providing care.
- Provide a periodic exercise program throughout the day (e.g. A walk to dine program).
- Encourage wheelchair/chair pushups, or assist the resident to stand periodically.
- Provide activities to assess and provide entertainment.
- Encourage repositioning frequently.

Environmental & Equipment Intervention

- Use assistive devices (wedge cushion, solid seat for wheelchair, side or trunk bolsters, pommel cushion, Dycem, etc.).
- Evaluate the resident for an appropriate size chair and proper fit.
- Evaluate alternative seating to relieve routine seating pressure/pain.
- Use an overstuffed chair, reclining wheelchair, non-wheeled chairs, or wingback chair.
- Place a call bell in reach of the resident.
- Provide an over-bed table to allow for diversional activities.
- Place a water pitcher in reach of the resident.
- Place the resident’s favorite items in their room to provide them comfort.
- Allow access to personal items that remind the resident of their family, especially photos.
- Encourage routine family visits with pets.
- Provide consistent caregivers.
- Evaluate if the resident’s environment can be modified to better meet their needs. (i.e. Determine if the resident’s environment can be more personalized.)

* A pain assessment should include non-verbal signs of pain. If you do not have a pain assessment that includes non-verbal identifiers, go to: http://www.dads.state.tx.us/qualitymatters/qcp/pain/painad.pdf

Continued
### What to consider when resident is disruptive in group functions

**Therapeutic Intervention**

- Evaluate new medications, antibiotics especially, and assess pain.
- Remove resident from group, evaluate for group stress.
- Determine if resident requires toileting.
- Determine if resident is hungry, and if so, provide them with a small snack.
  If the resident is thirsty, provide the resident a beverage.
- If this is a new behavior in a group, evaluate what is different this time.
- Assure resident has had a rest period prior to group activity.
- Assure there are no medical complications (low/high blood sugar).
- Assure resident is not in pain.*
- Return resident to group function, if possible.

**Environmental & Equipment Intervention**

- Determine whether clothing is appropriate for a particular function.
- Evaluate if the resident has well-fitting shoes, and ensure they do not rub the resident’s feet.
- Evaluate ambulation devices (wheelchair, walker) that are in good working condition.
- Ensure there is adequate lighting, especially at night.
- Ensure room/function is not overly crowded.
- Ensure room is not too warm or cold.
- Consider providing snacks and refreshments for all group functions.
- Ensure sound in group functions is loud enough so the resident can hear.
- Provide consistent caregivers.
- Evaluate if this program fits into the resident’s area of interest.

### What to consider with a sudden mood change, such as depression

**Therapeutic Intervention**

- Evaluate any new medications and assess pain*.
- Evaluate for orthostatic hypotension and change positions slowly.
- Reevaluate physical needs such as toileting, comfort, pain, thirst and timing of needs.
- Rule out medical problem (high/low blood sugar changes).
- Engage resident in conversation about their favorite activity, positive experiences, pets, etc.
- Touch if appropriate while recognizing personal body space.
- Anticipate customary schedules and accommodate personal preferences.
- Evaluate balance for sub-clinical disturbances such as inner ear infections.
- Validate feelings and mobilize the resident. For instance, if the resident states, I want to get up, reply, You want to get up? to confirm you heard them correctly. If so, act on the resident’s request.
- Evaluate hearing and vision.
- Discern if talk therapy is possible.
- Assess sleep patterns.

**Environmental & Equipment Intervention**

- Assess for changes in the resident’s environment.
- Assess for changes in the resident’s equipment.
- Involve family members to assure them that there have been no changes within the family, without the facility’s knowledge.
- Provide routines for consistency.
- Provide consistent caregivers.
- Provide nightlights for security.
- Employ the use of a memory box.
- Employ functional maintenance / 24-hour plan.
- Encourage the resident, if able, to verbalize his or her feelings.
- Eliminate noise and disruption.
- Employ the use of a sensory room or tranquility room.
Verbally Abusive/Physically Abusive

Therapeutic Intervention

- Begin with medical evaluation to rule out physical or medication problems.
- Evaluate the resident for acute medical conditions such as urinary tract infections, upper respiratory infections, ear infections or other infections.
- Evaluate the resident for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges.
- Attempt to identify triggering events or issues that stimulate the behavior.
- Consider using a behavior tracking form to assist in identification of triggers and trending patterns.
- Consult with the resident’s family regarding past coping mechanisms that proved effective during times of increased stress levels.
- Provide companionship.
- Validate feelings such as saying, You sound like you are angry.
- Redirect.
- Employ active listening skills and address potential issues identified.
- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease you voice level.
- Provide a sense of safety by approaching in a calm/quiet demeanor.
- Provide rest periods.
- Provide social services referral if needed.
- Provide a psychologist/psychiatrist referral if needed.
- Provide touch therapy and/or massage therapy on the hands or back.
- Reduce external stimuli (overhead paging, TV, radio noise, etc.).
- Evaluate staffing patterns and trends.
- Evaluate sleep/wake patterns.
- Maintain a regular schedule.
- Limit caffeine.
- Avoid sensory overload.

Environmental & Equipment Intervention

- Use relaxation techniques (i.e. tapes, videos, music etc.).
- Help the resident create theme/memory/reminiscence boxes/books.
- Help the resident create a magnification box to create awareness of the resident’s voice level and provide feedback.
- Use a lava lamp, soothe sounders, and active mobile.
- Play tapes and videos of family and/or familiar relatives or friends.
- Move to a quiet area, possibly a more familiar area, if needed.
- Decrease external stimuli.
- Use fish tanks.
- Encourage family visits, and visits from favorite pets.
- Identify if another resident is a trigger for this behavior.

Pacing/Wandering At Risk for Elopement

Therapeutic Intervention

- Find ways to meet a resident’s needs to be needed, loved and busy while being sensitive to their personal space.
- Provide diverse activities that correspond with past lifestyles/preferences.
- Consider how medications affect, Activities of Daily Living schedule, weather or how other residents affect wandering.
- Evaluate the need for a Day Treatment Program for targeted residents.
- Help resident create theme/memory/reminiscence boxes.
- Provide companionship.
- Provide opportunities for exercise particularly when waiting.
- Pre-meal activities.
- Singing, rhythmic movements, dancing, etc.
- Identify customary routines and allow for preferences.
- Help the resident create a photo collage or album of memorable events.
- Provide structured, high-energy activities and subsequent relaxation activities.
- Take the resident for a walk.
- Provide distraction and redirection.
- Provide written/verbal reassurance about where he/she is and why.
- Alleviate fears.
- Ask permission before you touch, hug etc.
- Assess/evaluate if there is a pattern in the pacing or wandering.
- Assess for resident’s personal agenda and validate behaviors.
- Ask family to record reassuring messages on tape.
- Evaluate for a restorative program.
- Perform a physical workup.

Environmental & Equipment Intervention

- Remove objects that remind the patient/resident of going home (hats, coats, etc.).
- Individualize the environment. Make the environment like the resident’s home. Place objects within the environment that are familiar to the resident.
- Place a large numerical clock at the resident’s bedside to provide orientation to time of day as it relates to customary routines.
- Ensure the courtyard is safe for the resident.
- Decrease noise level (especially overhead paging).
- Evaluate floor patterns.
- Evaluate rest areas in halls.
- Evaluate camouflaging of doors.
- Evaluate visual cues to identify safe areas.
- Play a favorite movie or video.
- Put unbreakable or plastic mirrors at exits.
- Place Stop and Go signs.
- Evaluate the WanderGuard system.
- Use relaxation tapes.
- Evaluate and use, as necessary, visual barriers and murals.
- Evaluate wandering paths.
- Evaluate room identifiers.
Validated Geriatric Pain Scales
The Numeric Pain Rating Scale Instructions

General Information:
- The patient is asked to make three pain ratings, corresponding to current, best and worst pain experienced over the past 24 hours.
- The average of the 3 ratings was used to represent the patient’s level of pain over the previous 24 hours.

Patient Instructions (adopted from (McCaffery, Beebe et al. 1989):
“Please indicate the intensity of current, best, and worst pain levels over the past 24 hours on a scale of 0 (no pain) to 10 (worst pain imaginable)”

Reference:
Faces Pain Scale – Revised (FPS-R)

Instructions: "These faces show how much something can hurt. This face [point to left-most face] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to right-most face] – it shows very much pain. Point to the face that shows how much you hurt [right now]." Numbers are not shown to the resident.

Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Note: The scale is intended to measure how a resident feels inside, not how their face looks.

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Verbal Descriptive Scale
**Pain Assessment in Advanced Dementia Scale (PAINAD)**

*Instructions*: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing Independent of vocalization</td>
<td>Normal</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cheyne-Stokes respirations</td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Repeated troubled calling out</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low-level speech with a negative or disapproving quality</td>
<td>Loud moaning or groaning</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or inexpressive</td>
<td>Sad</td>
<td>Rigid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frightened</td>
<td>Fists clenched</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Frown</td>
<td>Knees pulled up</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Pulling or pushing away</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Striking out</td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>Tense</td>
<td>Rigid</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Distressed pacing</td>
<td>Fists clenched</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Fidgeting</td>
<td>Knees pulled up</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Pulling or pushing away</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Striking out</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract, or reassure</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

(Warden et al., 2003)

**Scoring:**
The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

**Source:**
PAINAD Item Definitions
(Warden et al., 2003)

Breathing
1. **Normal breathing** is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. **Occasional labored breathing** is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. **Short period of hyperventilation** is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. **Noisy labored breathing** is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. **Long period of hyperventilation** is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. **Cheyne-Stokes respirations** are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization
1. **None** is characterized by speech or vocalization that has a neutral or pleasant quality.
2. **Occasional moan or groan** is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. **Low level speech with a negative or disapproving quality** is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. **Repeated troubled calling out** is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. **Loud moaning or groaning** is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. **Crying** is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression
1. **Smiling or inexpressive.** Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. **Sad** is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. **Frightened** is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. **Frown** is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. **Facial grimacing** is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language
1. **Relaxed** is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. **Tense** is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. **Distressed pacing** is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. **Fidgeting** is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. **Rigid** is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. **Fists clenched** is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. **Knees pulled up** is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. **Pulling or pushing away** is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. **Striking out** is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability
1. **No need to console** is characterized by a sense of well-being. The person appears content.
2. **Distracted or reassured by voice or touch** is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. **Unable to console, distract, or reassure** is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.
Tools and Resources
Certified Nursing Assistant Pain Recognition Tool

This observation tool is intended to assist the CNA to recognize pain in residents who have dementia that cannot verbally express their pain. The CNA can better assist the resident if they understand these common non-communication signs of pain.

Before marking the appropriate non-communication sign, you will observe the resident for one full minute. **Circle the responses that best describe the resident’s non-communication signs.** If a resident has a frown and appears sad, you would circle those two items and score a 1 as the total score for Facial Expressions. If there is not a word accurately describes the resident, chose the closest description.

*Please note that if you see a resident calling out/moaning, you should check off that box regardless of whether it is “normal” for that resident or not. Sometimes what we see as “normal” for that individual, could be an expression of untreated pain or an unmet need. This applies to each category. If you see it, you should check it off.*

<table>
<thead>
<tr>
<th>Non-communication Sign</th>
<th>SCORE</th>
<th>Total score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial Expressions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Smiling / pleasant</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>• Sad</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>• Frown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clenching jaw</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scared</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavior</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Engaged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laughing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Moaning / crying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aggressive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Agitated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Troubled calling out 'help&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Content</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Playful / joking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Anxious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Angry</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Body Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relaxed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Normal mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Distressed pacing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Guarding body part</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Striking out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pulling away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Wringing hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Activity Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Involved in regular activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Body movement normal for individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refusing to get out of bed / chair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Not interested in usual activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Decline in ADLs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CNA Name:</strong></td>
<td></td>
<td><strong>Total:</strong></td>
</tr>
</tbody>
</table>

Score of 1 or greater could be an indication of pain.

CNA notified (nurse name) ________________________________ that non-communication signs may indicate that resident is experiencing pain.

Comments:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
### Pain Management Communication

**Physician/ARNP Name:**

**Patient Name:** ____________________  DOB: _____/_____/_____

- [ ] Cognitively Impaired?  (check if yes)
- **Observed Behaviors:**
  - Whining
  - “Ouch”
  - Wincing
  - Bracing
  - Gasping
  - “That hurts”
  - Wrinkled forehead
  - Guarding
  - Furrowed brow
  - Rubbing body part/area
  - Clenched jaw
  - Clutching/holding body part/area during movement
  - Guarding
  - Other:

#### Pain Intensity:
- **Standard pain scale used:**
  - [ ] Numeric Rating Scale (0-10)
  - [ ] Verbal Descriptor Scale (no pain, mild pain, moderate pain, severe pain, extreme pain, pain as bad as could be)
  - [ ] Faces Pain Scale
  - [ ] PAINAD; score: __________________
  - [ ] Other: _____________________________

#### Pain Interferes with:
- [ ] Sleep
- [ ] Ambulation
- [ ] Appetite
- [ ] Activities
- [ ] Transfers

#### Types of Pain:
- [ ] Neuropathic
- [ ] Nociceptive (Joint/bone/soft tissue)
- [ ] Other: _____________________________

#### Location(s) of Pain:

#### Pain Pattern:
- [ ] Constant
- [ ] Intermittent
- [ ] Constant with Breakthrough

#### Quality of Pain (use descriptive adjectives of patient):
- [ ] Aching
- [ ] Burning
- [ ] Cramping
- [ ] Crushing
- [ ] Dull
- [ ] Numbness
- [ ] Pins & Needles
- [ ] Sharp
- [ ] Stabbing
- [ ] Throbbing
- [ ] Other: _____________________________

**Current analgesic regimen:**

**Analgesics tried in the past:**

**Relevant side effects:**

**Treatment Suggestions**

**Patient/Family requests**

**Nurse requests**

**Date:** _____/_____/_______  RN Signature: ____________________

**New Orders**
- [ ] Continue Same Orders
- [ ] Change Orders as Follows:

**Date:** _____/_____/_______  Physician/ARNP Signature: ____________________

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Cancer Pain in Elders: Promoting EBP’s in Hospices
NCI Grant R01 CA115363; Keela Herr, PhD, RN, FAAN, The University of Iowa
## ONSET, PEAK AND DURATION OF COMMON PAIN MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Onset of Action (minutes)*</th>
<th>Peak Effect (hours)*</th>
<th>Duration of Action (hours)*</th>
<th>Route of Admin.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Opioid Analgesics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>30-45</td>
<td>0.5-1</td>
<td>4-6</td>
<td>Oral</td>
<td>Headache, nausea, vomiting May cause hepatic complications in doses over 3000mg/24hr in the elderly</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Analgesia: 30-60 Anti-inflammatory: Up to 7 days Analgesia: unknown Anti-inflammatory: 1-2 weeks with routine administration</td>
<td>Analgesia: 4-6</td>
<td>Oral</td>
<td>Nausea, vomiting, headache, dizziness rash, flatulence, heartburn, anemia, hypokalemia, cardiovascular risks, peptic ulcer, GI bleeding; not recommended for use with moderate to severe renal impairment</td>
<td></td>
</tr>
<tr>
<td>Naproxen sodium</td>
<td>Analgesia: 30-60 Anti-inflammatory: within 2 weeks Analgesia: unknown Anti-inflammatory: 2-4 weeks with routine administration</td>
<td>Analgesia: 4-6 Up to 7 Please consider up to 12</td>
<td>Oral</td>
<td>Headache, dizziness, rash, edema, alterations in blood pressure, abdominal pain, cardiovascular risks, peptic ulcer, GI bleeding, not recommended for use with moderate to severe renal impairment</td>
<td></td>
</tr>
<tr>
<td><strong>Opioid Analgesics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>15-30</td>
<td>0.5-1</td>
<td>4-6</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Unknown</td>
<td>20-72</td>
<td>72</td>
<td>Transdermal Patch</td>
<td>Monitor patients closely for respiratory depression, especially within the first 24-72 hrs of initiating therapy. Rotate transdermal patch to different skin sites after removal of the previous patch. Do not apply to those with elevated body temperature such as heating pads, hot baths, or fever</td>
</tr>
<tr>
<td>Hydrocodone (combinations)</td>
<td>10-30</td>
<td>0.5-1</td>
<td>4-6</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>30</td>
<td>0.5-1</td>
<td>3-4</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis</td>
</tr>
</tbody>
</table>
## ONSET, PEAK AND DURATION OF COMMON PAIN MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Onset of Action (minutes)*</th>
<th>Peak Effect (hours)*</th>
<th>Duration of Action (hours)*</th>
<th>Route of Admin.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>30-60</td>
<td>1-2</td>
<td>4-6</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis, life-Threatening QT Prolongation, monitor patients closely for respiratory depression, especially within the first 24 to 72 hours, narrow therapeutic index (dose carefully)</td>
</tr>
<tr>
<td>Morphine, immediate release</td>
<td>15-60</td>
<td>1</td>
<td>3-6</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis</td>
</tr>
<tr>
<td>Oxycodone, immediate release</td>
<td>15</td>
<td>1-2</td>
<td>3-4</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>5-15</td>
<td>0.5-1</td>
<td>3-6</td>
<td>Oral</td>
<td>Sedation, nausea/vomiting, constipation, respiratory depression, delirium, pruritis</td>
</tr>
<tr>
<td>Tramadol, immediate release</td>
<td>60</td>
<td>2-3</td>
<td>6</td>
<td>Oral</td>
<td>Dizziness, constipation, vertigo, nausea, headache, somnolence, agitation, anxiety, emotional lability</td>
</tr>
<tr>
<td>Muscle relaxants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baclofen</td>
<td>3-4 days</td>
<td>5-10 days</td>
<td>4-6</td>
<td>Oral</td>
<td>Drowsiness, dizziness, nausea, confusion, headache, constipation, urinary frequency</td>
</tr>
<tr>
<td>Tizanidine</td>
<td>Unknown</td>
<td>1-2</td>
<td>3-6</td>
<td>Oral</td>
<td>Dry mouth, somnolence, dizziness, asthenia, constipation, blurred vision</td>
</tr>
</tbody>
</table>

*Unless otherwise specified

Quick onset of action times found within this table may account for the drug’s absorption in the oral liquid form. Onset of action can also differ due to the manufacturer’s variability with tablet compression effecting disintegration and dissolution times when ingested.
SUGGESTED LANGUAGE TO INTRODUCE THE INTERVIEW:

“I’d like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain.”

<table>
<thead>
<tr>
<th>Pain Assessment Interview</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>J0300. Pain Presence</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>Ask resident: <em>Have you had pain or hurting at any time in the last 5 days?</em></td>
<td></td>
</tr>
<tr>
<td>0. No — Skip to J1100, Shortness of Breath</td>
<td></td>
</tr>
<tr>
<td>1. Yes — Continue to J0400, Pain Frequency</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer — Skip to J0800, Indicators of Pain or Possible Pain</td>
<td></td>
</tr>
<tr>
<td><strong>J0400. Pain Frequency</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>Ask resident: <em>How much of the time have you experienced pain or hurting over the last 5 days?</em></td>
<td></td>
</tr>
<tr>
<td>1. Almost constantly</td>
<td></td>
</tr>
<tr>
<td>2. Frequently</td>
<td></td>
</tr>
<tr>
<td>3. Occasionally</td>
<td></td>
</tr>
<tr>
<td>4. Rarely</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
<tr>
<td><strong>J0500. Pain Effect on Function</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>A. Ask resident: <em>Over the past 5 days, has pain made it hard for you to sleep at night?</em></td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
<tr>
<td>Enter Code</td>
<td></td>
</tr>
<tr>
<td>B. Ask resident: <em>Over the past 5 days, have you limited your day-to-day activities because of pain?</em></td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
<tr>
<td><strong>J0600. Pain Intensity</strong></td>
<td></td>
</tr>
<tr>
<td>Enter Rating</td>
<td></td>
</tr>
<tr>
<td>A. Numeric Rating Scale (00-10)</td>
<td></td>
</tr>
<tr>
<td>Ask resident: <em>Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.</em> (Show resident 00-10 pain scale)</td>
<td></td>
</tr>
<tr>
<td>Enter two-digit response. Enter 99 if unable to answer.</td>
<td></td>
</tr>
<tr>
<td>B. Verbal Descriptor Scale</td>
<td></td>
</tr>
<tr>
<td>Ask resident: <em>Please rate the intensity of your worst pain over the last 5 days.</em> (Show resident verbal scale)</td>
<td></td>
</tr>
<tr>
<td>1. Mild</td>
<td></td>
</tr>
<tr>
<td>2. Moderate</td>
<td></td>
</tr>
<tr>
<td>3. Severe</td>
<td></td>
</tr>
<tr>
<td>4. Very severe, horrible</td>
<td></td>
</tr>
<tr>
<td>9. Unable to answer</td>
<td></td>
</tr>
</tbody>
</table>
Section J: Health Conditions

J0400  Pain Frequency

How much of the time have you experienced pain or hurting over the last 5 days?

1. Almost constantly
2. Frequently
3. Occasionally
4. Rarely
<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Worst pain you can imagine</td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>No pain</td>
</tr>
</tbody>
</table>
Please rate your worst pain over the last 5 days:

Mild
Moderate
Severe
Very severe, horrible