Assessing Pain in Older Adults with Dementia

By: Ann L. Horgas, RN, PhD, FGSA, FAAN, University of Florida College of Nursing

WHY: Pain in older adults is very often undertreated, and it may be especially so in older adults with severe dementia. Changes in a patient's ability to communicate verbally present special challenges in treating pain, since self-report is considered the gold standard of pain assessment. 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 from surgery, injury, and infection. Untreated pain in cognitively impaired older adults can delay healing, disturb sleep and activity patterns, reduce function, reduce quality of life, and prolong hospitalization.

BEST TOOLS: The best tool for use in this population is a comprehensive pain assessment (Horgas, 2017) that includes self-report and objective measures of pain. Reid and colleagues (2015) provide a comprehensive protocol and geriatric pain assessment form.

For patients with dementia, the American Society for Pain Management Nursing's Task Force on Pain Assessment in the Nonverbal Patient (Herr, Coyne, et al., 2006) recommends a comprehensive, hierarchical approach to pain assessment that incorporates the following steps:

- Ask older adults with dementia about their pain. Even older adults with mild to moderate dementia can respond to simple questions about their pain.
- If pain is suspected, consider a time-limited trial of an appropriate type and dose of an analgesic agent.
- Thoroughly investigate behavior changes to rule out another cause.
- Use an observational tool to measure the presence of pain in older adults with dementia. Choose one and use it consistently to assess change over time.
- Ask family or usual caregivers as to whether the patient's current behavior (e.g., 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 an appropriate type and dose of an analgesic agent. Thoroughly investigate behavior changes to rule out other causes. Use self-report and observational pain measures to evaluate the pain before and after administering the analgesic.

Several objective tools are available to measure pain in older adults with dementia. The Pain Assessment in Advanced Dementia Scale (PAINAD) has been widely used, translated into many languages, and endorsed by The American Medical Directors Association (Warden, Hurley, & Volicer, 2003). The PAINAD assesses five items: breathing, negative vocalizations, facial expression, body language, and consolability. Items are scored on a 0-2 scale and summed. A sum score of 2 is considered a cut-off value that should trigger pain treatment (Zwakhalen, van der Steen, & Najim, 2012).

More recently, the Mobilization-Observation-Behaviour–Intensity-Dementia Pain Scale (MOBID-2) has gained support as a reliable and valid measure of pain behaviors in patients with advanced dementia (Husebo et al., 2010). Pain behaviors of vocalizations, facial expressions (e.g., grimacing), and body movements (e.g., defensive positions such as guarding or pushing) are assessed. The MOBID-2 has two parts. Part 1 assesses pain related to the musculoskeletal system (the most common cause of pain in older adults) during a set of standardized, guided movements during morning care (5 items). Part 2 assesses pain that might originate from internal organs, head, and skin and is monitored over time (5 items). If a pain behavior is detected, pain intensity is rated by direct caregivers using a 0-10 numerical rating scale.

TARGET POPULATION: Older adults with cognitive impairment who cannot be assessed for pain using standardized pain assessment instruments. Pain assessment in older adults with cognitive impairment is essential for both planned or emergent hospitalization.

VALIDITY AND RELIABILITY: PAINAD: The PAINAD has an internal consistency reliability ranging from 0.50 (for behavior assessed at rest) to 0.67 (for behaviors assessed during unpleasant caregiving activities). Inter-rater reliability is high (r = 0.82 - 0.97). The PAINAD scale is reported to have moderate to high concurrent validity, depending on whether the patient was at rest or involved in pleasant or unpleasant activities (r = 0.76 to 0.95).

MOBID-2: The MOBID-2 has demonstrated high inter- and intra-rater and test-retest reliability (Sandvik et al., 2014). Internal consistency reliability was also high, with Cronbach's alpha ranging from 0.82 - 0.84 (Husebo et al., 2010). Importantly, the MOBID-2 has demonstrated sensitivity to pain treatment and, to date, is the only behavioral measure to establish this important dimension of pain treatment (Husebo, Ostebo, & Strand, 2014).

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 usual caregivers.

BARRIERS TO PAIN MANAGEMENT IN OLDER ADULTS WITH DEMENTIA: There are many barriers to effective pain management in this population. Some common myths are: pain is a normal part of aging; if a person doesn't verbalize that they have pain, they must not be experiencing it; and that strong analgesics (e.g., opioids) must be avoided.

There are also some barriers to using observational tools to assess pain in this population. Some of the PAINAD scale behaviors, such as breathing and consolability, may be difficult to assess. The MOBID-2 requires assessment during movement and caregiver must be trained in use of the tool.

SUMMARY: An effective approach to pain management in older adults with dementia is to assume that they do have pain if they have conditions and/or medical procedures that are typically associated with pain. Take a proactive approach in pain assessment and management. The use of a standardized pain assessment tool is important in measuring pain. It enables health care providers to document their assessment, measure change in pain, evaluate treatment effectiveness, and communicate to other health care providers, the patient, and the family.

MORE ON THE TOPIC: Best practice information on care of older adults: https://consultgeri.org.


Permission is hereby granted to reproduce, post, download, and/or distribute this material in its entirety for not-for-profit educational purposes only, provided that the Hartford Institute for Geriatric Nursing, New York University Rory Meyers College of Nursing is cited as the source. This material may be downloaded and/or distributed in electronic format, including PDA format. Available on the internet at www.ConsultGeri.org. E-mail notification of usage to: nursing.hign@nyu.edu.
Pain Assessment in Advanced Dementia (PAINAD) Scale

<table>
<thead>
<tr>
<th>Items*</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low level speech with a negative or disapproving quality.</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying.</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>

* Items* 0 1 2 Score
5. Long period of hyperventilation is characterized by
4. Noisy labored breathing is characterized by
3. Short period of hyperventilation is characterized by
2. Occasional labored breathing is characterized by episodeic bursts of harsh, difficult or wearing respirations.
1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.

** Five-item observational tool (see the description of each item below).
** Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0 = no pain to 10 = severe pain).