

CONCISE GUIDANCE TO GOOD PRACTICE

A series of evidence-based guidelines for clinical management

NUMBER 8

The assessment of pain in older people

NATIONAL GUIDELINES

October 2007



Acknowledgements

The Guideline Development Group (GDG) would like to thank and acknowledge the support received from Jo Gough for her administrative help in organising the activities of the GDG and in assisting with the drafting of the guidance.

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Clinical Standards Department

The aim of the Clinical Standards Department of the Royal College of Physicians is to improve patient care and healthcare provision by setting clinical standards and monitoring their use. We have expertise in the development of evidence-based guidelines and the organisation and reporting of multicentre comparative performance data. The department has three core strategic objectives: to *define* standards around the clinical work of physicians, to *measure* and evaluate the implementation of standards and its impact on patient care and to effectively *implement* these standards.

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Concise Guidance to Good Practice series

The concise guidelines in this series are intended to inform those aspects of physicians' clinical practice which may be outside their own specialist area. In many instances, the guidance will also be useful for other clinicians including GPs, and other healthcare professionals.

The guidelines are designed to allow clinicians to make rapid, informed decisions based wherever possible on synthesis of the best available evidence and expert consensus gathered from practising clinicians and service users. A key feature of the series is to provide both recommendations for best practice, and where possible practical tools with which to implement it.

Series Editors: Lynne Turner-Stokes FRCP and Bernard Higgins FRCP

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Foreword

Pain is so universal that it is essential that it is recognised by all people working with older people. It places a blight on daily life, limiting functional ability and impairing the quality of life. The symptom manifests itself in many ways, not only as a sensory experience but also by causing psychological distress.

It may be difficult for some to articulate their pain, for example those with dementia, some forms of stroke or Parkinson's disease. The non-verbal manifestations of pain must be recognised and interpreted so that the distress caused to these most vulnerable members of society can be alleviated.

The National Service Framework (NSF) for Older People placed great emphasis on the dignity of older people. The appropriate management of pain is essential to ensure the dignity and well-being of older people. This important need has been reiterated in my review of progress with the NSF and plans for the next phase in *A new ambition for old age*.*

It is timely therefore that the British Pain Society has worked with the British Geriatrics Society and the Royal College of Physicians to review the current evidence in the literature and to produce sound guidance to help all practitioners in assessing for the presence of pain.

I fully commend the guidance presented here, and hope that health and social practitioners will take heed and utilise it in their everyday practice.

October 2007

Ian Philp
National Director for Older People,
Department of Health

*Department of Health. *A new ambition for old age: next steps in implementing the National Service Framework for Older People*. A report from Professor Ian Philp, National Director for Older People. London: DH, 2007

Pain is under-recognised and under-treated in older people. It is a subjective, personal experience, only known to the person who suffers. The assessment of pain is particularly challenging in the presence of severe cognitive impairment, communication difficulties or language and cultural barriers.

These guidelines set out the key components of assessing pain in older people, together with a variety of practical scales that may be used with different groups, including those with cognitive or communication impairment. The purpose is to provide professionals with a set of practical skills to assess pain as the first step towards its effective management. The guidance has implications for all healthcare and social care staff and can be applied in all settings, including the older person's own home, in care homes, and in hospital.

Methodology

The guidance has been developed in accordance with the requirements for concise guidelines as detailed at www.rcplondon.ac.uk/college/ceeu/conciseGuidelineDevelopmentNotes.pdf

Details are shown in Appendix 1.

Background

Pain is under-recognised and under-treated in older people. National UK statistics have indicated that pain or discomfort was reported by about half of those over 65 years old, and 56% of men and 65% of women aged 75 years and over.¹ Higher prevalence estimates are obtained from samples of institutionalised older people, where 45–83% of patients report at least one current pain problem.^{2,3}

Pain is a subjective, personal experience, only known to the person who suffers. The experience of pain is

multidimensional and may be described at several levels:

- sensory dimension: the intensity, location and character of the pain sensation
- affective dimension: the emotional component of pain and how pain is perceived
- impact: the disabling effects of pain on the person's ability to function and participate in society.

The purpose of this guideline is to provide professionals with a set of practical skills to assess pain as the first step towards its effective management. The guidance does not seek to differentiate between acute and persistent pain as the literature relating to pain in older people shows that such a distinction is impractical.

For more detailed guidance and evaluation of the supporting literature, please see the full guideline.^{4,5}

The challenge of impaired cognition and communication

Assessing pain becomes even more challenging in the presence of severe cognitive impairment, communication difficulties or language and cultural barriers. However, even in the presence of severe cognitive and communication impairment, many individuals may have their pain assessed using appropriate observational scales.

Verbal and numerical rating scales best quantify the intensity of pain in older people with no cognitive/communication impairment and can also be used with appropriate assistance in many patients with mild to moderate impairments.

Rating scales should be presented in a format that is accessible to the particular individual. People who lack verbal and numeracy skills, eg those with cognitive impairment or communication impairment following stroke, may be able to respond to a suitably adapted pictorial rating scale.^{6–8} Assistance from a speech and language therapist or psychologist may help to facilitate self-report in the presence of more severe impairment.

Scales should use large clear letters/numbers and be presented under good lighting. Once the most appropriate scale has been chosen to suit the individual person's strengths, staff should continue to use this for sequential assessment in order to observe the response to treatment.

People with very severe cognitive/communication impairment may not be able to self-report pain even with full assistance. Clinicians may need to rely on behavioural responses, but these can be hard to interpret.

Assessment

The key components of an assessment for anyone suffering from pain are shown in Box 1.

It is particularly important to use observations for signs of pain in older people with cognitive or communication impairment (Table 1).

For an algorithm for assessment, see Appendix 2. For an example of a pain map, see Appendix 3.

Box 1. Key components of an assessment of pain.

Direct enquiry about the presence of pain

- including the use of alternative words to describe pain

Observation for signs of pain

- especially in older people with cognitive/communication impairment

Description of pain to include:

- sensory dimension
 - the nature of the pain (eg sharp, dull, burning etc)
 - pain location and radiation (by patients pointing to the pain on themselves or by using a pain map)
 - intensity, using a standardised pain assessment scale
- affective dimension
 - emotional response to pain (eg fear, anxiety, depression)
- impact: disabling effects of pain at the levels of
 - functional activities (eg activities of daily living)
 - participation (eg work, social activities, relationships)

Measurement of pain

- using standardised scales in a format that is accessible to the individual

Cause of pain

- examination and investigation to establish the cause of pain

Table 1. Observational changes associated with pain.

Type	Description
Autonomic changes	Pallor, sweating, tachypnoea, altered breathing patterns, tachycardia, hypertension
Facial expressions	Grimacing, wincing, frowning, rapid blinking, brow raising, brow lowering, cheek raising, eyelid tightening, nose wrinkling, lip corner pulling, chin raising, lip puckering
Body movements	Altered gait, pacing, rocking, hand wringing, repetitive movements, increased tone, guarding,* bracing**
Verbalisations/vocalisations	Sighing, grunting, groaning, moaning, screaming, calling out, aggressive/offensive speech
Interpersonal interactions	Aggression, withdrawal, resisting
Changes in activity patterns	Wandering, altered sleep, altered rest patterns
Mental status changes	Confusion, crying, distress, irritability

*Guarding = 'abnormal stiff, rigid, or interrupted movement while changing position'.

**Bracing = a stationary position in which a fully extended limb maintains and supports an abnormal weight distribution for at least three seconds.

Table 2. Types of scale for assessing pain.

Type of pain assessment	Practical suggestions for scale selection	Comments and references
<i>Self-report</i>		
Older people with no significant cognitive/communication impairment	Numeric graphic rating scale (Appendix 4)	High validity and reliability in older people ^{9–11}
<i>and</i> Older people with mild to moderate cognitive/communication impairment	Verbal rating scale or numerical rating scale (0–10) (Appendix 4)	Can be used in mild/moderate cognitive impairment ^{9,12} Vertical as opposed to horizontal orientation may help to avoid misinterpretation in the presence of visuo-spatial neglect, eg in patients with stroke High validity and reliability in older people ^{9–11}
Older people with moderate to severe cognitive/communication impairment	Pain Thermometer ⁶ (Appendix 4) Coloured Visual Analogue Scale ⁷	Easy to use Validity has not been fully evaluated ⁶ Well understood in early and mid-stage stage Alzheimer's disease ⁸
<i>Observational pain assessment</i>		
Older people with severe cognitive/communication impairment (no single recommendation currently possible)	Abbey Pain Scale (Appendix 4) ^{13,14}	Short and easy to apply scale ¹³ Requires more detailed evaluation
<i>Multidimensional assessment</i>		
Older people with minimal cognitive impairment	Brief Pain Inventory ^{15,16}	15-item scale assessing: severity, impact on daily living, impact on mood and enjoyment of life

Types of scale used to assess pain

A list of existing scales and the evidence for their use is available in the full guideline.^{4,5}

Table 2 provides examples of scales which are suitable for clinical use in different categories of patient. It is not yet clear which observational scale is the most suitable for widespread use with people who have severe cognitive impairment, so an example has been selected on the basis of simplicity and availability. Ongoing validation studies are likely to inform the selection of scales for use in the near future.

Implications and implementation

The guidance has implications for all healthcare and social care staff and can be applied in all settings, including the older person's own home, in care homes, and in hospital.

There is no significant funding implication for implementation, but rather a requirement that all healthcare professionals think about the possibility of pain in all contacts with older people, enquire about it routinely, be aware of behaviours that indicate underlying pain and have pathways for management.

SUMMARY OF THE GUIDELINES

<i>Recommendation</i>	<i>Grade</i>
1 Pain awareness All healthcare professionals should be alert to the possibility of pain in older people, and to the fact that older people are often reluctant to acknowledge and report pain.	C
2 Pain enquiry Any health assessment should include enquiry about pain, using a range of alternative descriptors (eg sore, hurting, aching).	C
3 Pain description Where pain is present, a detailed clinical assessment of the multidimensional aspects of pain should be undertaken including: <ul style="list-style-type: none">• <i>sensory dimension</i>: the nature, location and intensity of pain• <i>affective dimension</i>: the emotional component and response to pain• <i>impact</i>: on functioning at the level of activities and participation.	C
3.1 Pain location An attempt to locate pain should be made by: <ul style="list-style-type: none">• asking the patient to point to the area on themselves• the use of pain maps to define the location and the extent of pain.	C
3.2 Pain intensity Pain assessment should routinely include the use of a standardised intensity rating scale, preferably a simple verbal descriptor scale or a numeric rating scale, if the person is able to use these.	C
4 Communication Every effort should be made to facilitate communication particularly with those people with sensory impairments (use of hearing aids, glasses etc). Self-report assessment scales should be offered in an accessible format to suit the strengths of the individual.	C
5 Assessment in people with impaired cognition/communication People with moderate to severe communication problems should be offered additional assistance with self-report through the use of suitably adapted scales and facilitation by skilled professionals. In people with very severe impairment, and in situations where procedures might cause pain, an observational assessment of pain behaviour is additionally required (see Table 1). Pain behaviours differ between individuals, so assessment should include insights from familiar carers and family members to interpret the meaning of their behaviours.	C
6 Cause of pain Careful physical examination should be undertaken to identify any treatable causes. However, staff should be aware that pain can exist even if physical examination is normal.	C
7 Re-evaluation Once a suitable scale has been identified, serial assessment should be undertaken using the same instrument to evaluate the effects of treatment.	C

The proper evaluation of pain in older people does require staff training and the additional time required to undertake a proper evaluation will inevitably impact on staff time in already over-pressed services. However, if pain is sought out, addressed and relieved, the lot of older people would be greatly enhanced. Moreover, relief from the disabling effects of pain may potentially save staff time in other areas such as the provision of support for basic self-care activities etc.

These basic guidelines should be a routine part of the training and care provision of all healthcare professionals.

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Appendix 1. Guideline development process

The full guidelines^{4,5} have been developed in accordance with the principles laid down by the Appraisal of Guidelines for Research and Evaluation collaboration.¹⁷

Scope and purpose

Overall objective of the guidelines	To provide simple and pragmatic advice for clinicians with regard to screening and assessment of pain in older adults
The patient group covered	All older people coming into contact with healthcare professionals
Target audience	All healthcare professionals, including those in primary care, hospitals and care home settings
Clinical areas covered	The assessment of pain

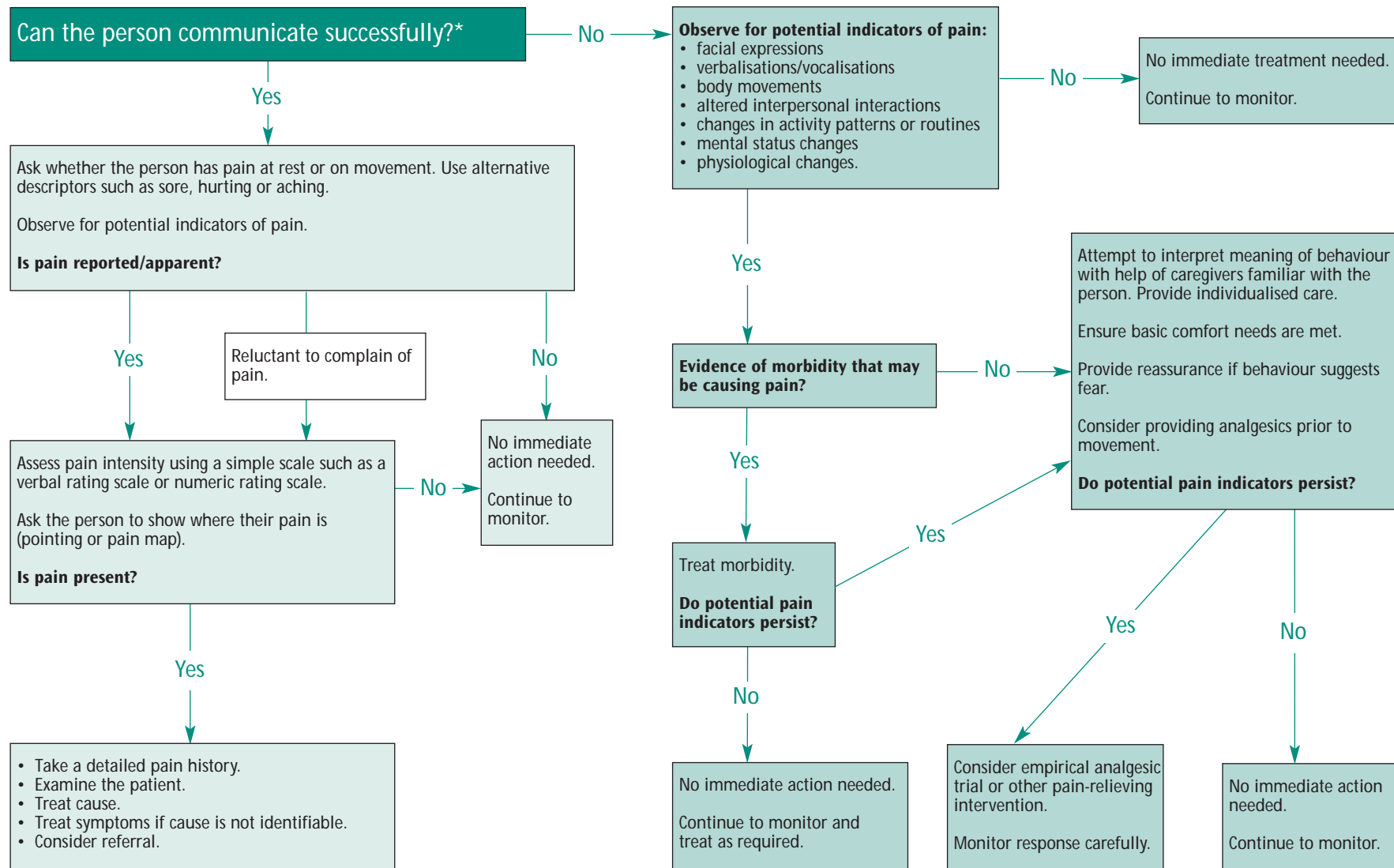
Stakeholder involvement

The Guideline Development Group	A multidisciplinary Guideline Development Group (GDG) was convened by the British Geriatrics Society and the British Pain Society in conjunction with the Clinical Standards Department of the Royal College of Physicians, with representatives from: <ul style="list-style-type: none">• nursing• pain medicine• patient group• geriatric medicine• physiotherapy.
Funding	British Pain Society British Geriatrics Society
Conflicts of interest	None declared

Rigour of development

Evidence gathering	<p><i>Search strategy:</i> Relevant full length articles were identified using electronic searches in Medline, PubMed, OVID Medline, CINAHL, EMBASE, AMED, SciSearch & Cochrane. Evidence-based reviews were identified from OVID, Cochrane, ACP Journal Club, DARE and CCTR. Psychological and social science literature was sought through PsychINFO and ASSIA. Conference papers were searched via IASP, the British Pain Society and the European Pain Society. Relevant publications were included.</p> <p><i>Inclusion criteria:</i> Papers describing original studies, evidence-based guidelines or systematic reviews Studies including older people (65 and over) with or without cognitive impairment Pain was defined as both acute and persistent, according to the International Association for the Study of Pain (IASP) definitions, but the focus was on persistent pain (www.iasp-pain.org/terms-p.html). Studies including pain assessment Papers published after 1990</p> <p><i>Exclusion criteria:</i> Paediatric literature</p> <p><i>Search terms:</i> Combination of search terms used included: pain or discomfort or agitation and assessment or scales or measurement or behavioural measures or multidimensional measures of pain or quality of life or depression or anxiety and older people or elderly or aged or dementia or cognitive impairment. Qualitative and quantitative studies were included.</p>
Review process	The Scottish Intercollegiate Guideline Network tool was used for critical appraisal. ¹⁸ Two centres were identified – Cardiff and Sheffield. Three reviewers conducted the appraisal in Sheffield and one reviewer in Cardiff.
Link between evidence and recommendations	The GDG developed recommendations on the basis of the evidence presented by the critical appraisal team.
Piloting and peer review	The guidance was circulated to a multiprofessional and international consensus group of 11 experts for peer review, prior to production of the final draft.

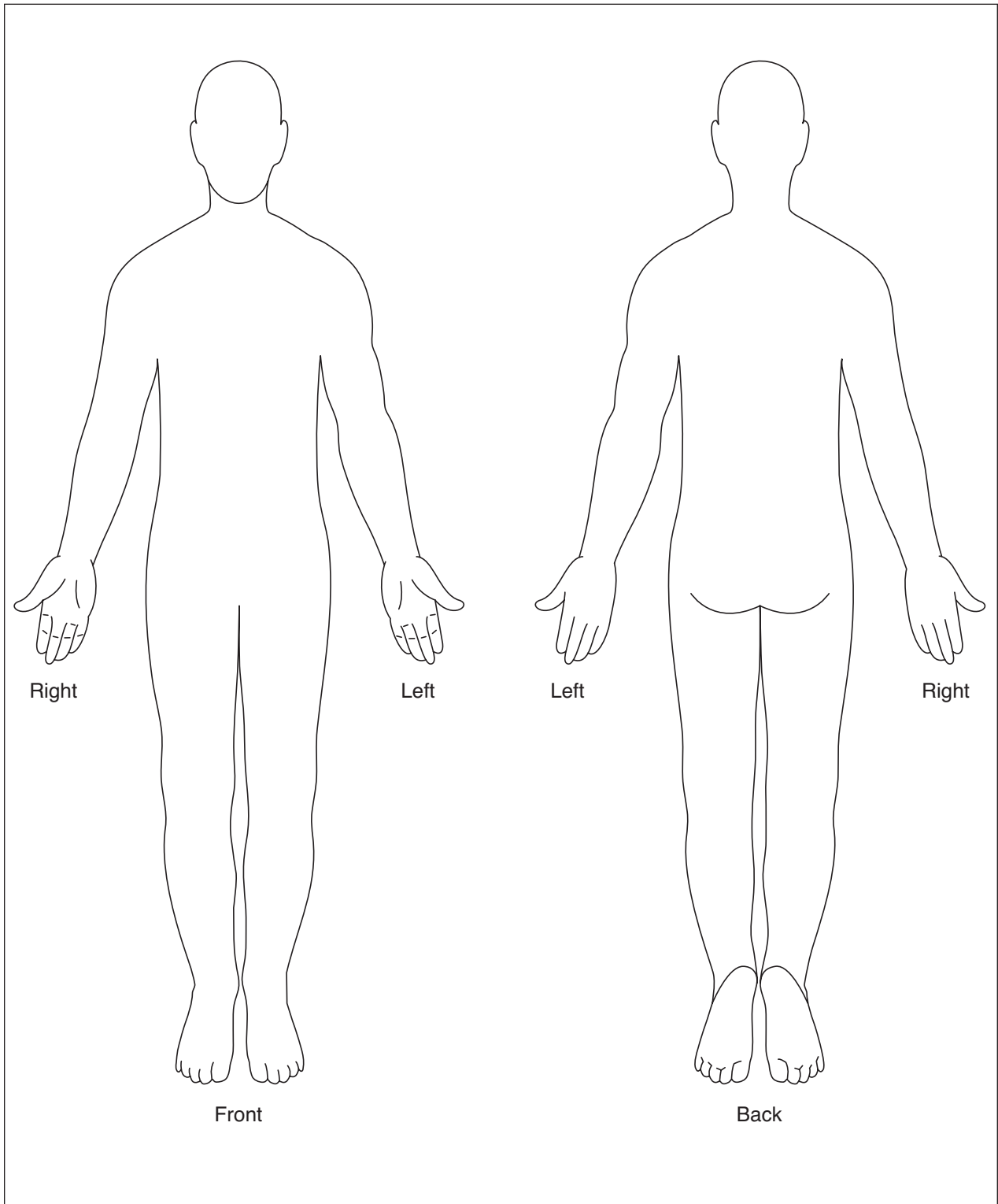
Appendix 2. Algorithm for the assessment of pain in older people



*If there is doubt about ability to communicate, assess and facilitate as indicated in Recommendations 4 and 5 of the Guidelines.

Appendix 3. Pain map

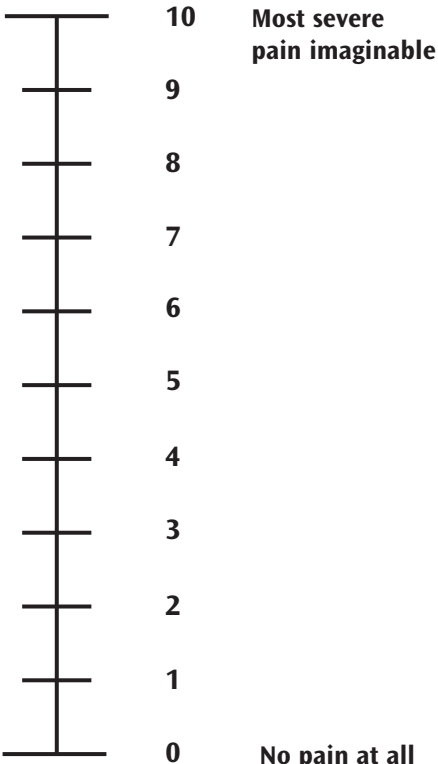
'Where is your pain? Please mark where you feel pain on the drawings below.'



Appendix 4. Examples of pain scales

4A Numeric rating scale

The Numeric Graphic Rating Scale (NGRS)



10 Most severe pain imaginable

9

8

7

6

5

4

3

2

1

0 No pain at all

Say to the patient:

- This is a scale to measure pain.
- 0 indicates 'no pain at all'.
- The numbers on the scale indicate increasing levels of pain, up to 10 which is the most severe pain imaginable.
- Which point on the scale shows how much pain you have today?

To the administrator:

In your opinion was the person able to understand this scale?

Yes No

Comment:

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4B Verbal descriptor rating scale (5 points)

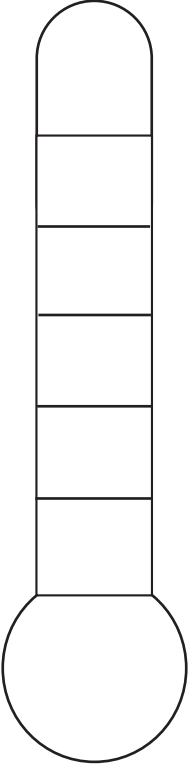
'How severe is your pain today?'

- None
- Mild
- Moderate
- Severe
- Very severe

4C Verbal numerical rating scale

'On a scale of 0 to 10, please tell me how severe your pain is today.'

4D Pain Thermometer



The diagram shows a vertical thermometer-like scale. It consists of a central vertical line with seven segments. The top segment is a rounded rectangle, and the bottom segment is a circle. The middle five segments are simple rectangles. To the right of each segment is a corresponding pain level label. From top to bottom, the labels are: 'Pain as bad as it could be', 'Extreme pain', 'Severe pain', 'Moderate pain', 'Mild pain', 'Slight pain', and 'No pain'.

	Pain as bad as it could be
	Extreme pain
	Severe pain
	Moderate pain
	Mild pain
	Slight pain
	No pain

Reproduced with permission from Professor Keela Herr, University of Iowa.

4E Abbey Pain Scale

Use of the Abbey Pain Scale

The Abbey Pain Scale is best used as part of an overall pain management plan. Some pain management strategies can be found in the website cited in Ref 19.

Objective

The Pain Scale is an instrument designed to assist in the assessment of pain in residents who are unable to clearly articulate their needs.

Ongoing assessment

The Scale does not differentiate between distress and pain, so measuring the effectiveness of pain-relieving interventions is essential.

Recent work by the Australian Pain Society²⁰ recommends that the Abbey Pain Scale be used as a movement-based assessment. The staff recording the scale should therefore observe the resident while they are being moved, eg during pressure area care, while showering etc.

Complete the scale immediately following the procedure and record the results in the resident's notes. Include the time of completion of the scale, the score, staff member's signature and action (if any) taken in response to results of the assessment, eg pain medication or other therapies.

A second evaluation should be conducted one hour after any intervention taken in response to the first assessment, to determine the effectiveness of any pain-relieving intervention.

If, at this assessment, the score on the pain scale is the same, or worse, consider further intervention and act as appropriate. Complete the pain scale hourly, until the resident appears comfortable, then four-hourly for 24 hours, treating pain if it recurs. Record all the pain-relieving interventions undertaken. If pain/distress persists, undertake a comprehensive assessment of all facets of resident's care and monitor closely over a 24-hour period, including any further interventions undertaken. If there is no improvement during that time, notify the medical practitioner of the pain scores and the action/s taken.

Jenny Abbey
April, 2007

The Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6.

Name of resident:

Name and designation of person completing the scale:

Date: Time:

Latest pain relief given was at hrs.

- | | | |
|--|----|---|
| <p>Q1. Vocalisation
eg whimpering, groaning, crying
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q1 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p>Q2. Facial expression
eg looking tense, frowning, grimacing, looking frightened
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q2 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p>Q3. Change in body language
eg fidgeting, guarding part of body, withdrawn
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q3 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p>Q4. Behavioural change
eg increased confusion, refusing to eat, alteration in usual patterns
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q4 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p>Q5. Physiological change
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q5 | <input style="width: 40px; height: 25px;" type="text"/> |
| <p>Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures, previous injuries
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i></p> | Q6 | <input style="width: 40px; height: 25px;" type="text"/> |

Add scores for Q1 to Q6 and record here ➔ Total pain score

Now tick the box that matches the Total pain score ➔

0-2 No pain	3-7 Mild	8-13 Moderate	14+ Severe
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Finally, tick the box which matches the type of pain ➔

Chronic	Acute	Acute on chronic
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Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D, Lowcay B. The Abbey Pain Scale. Funded by the JH & JD Gunn Medical Research Foundation 1998–2002.
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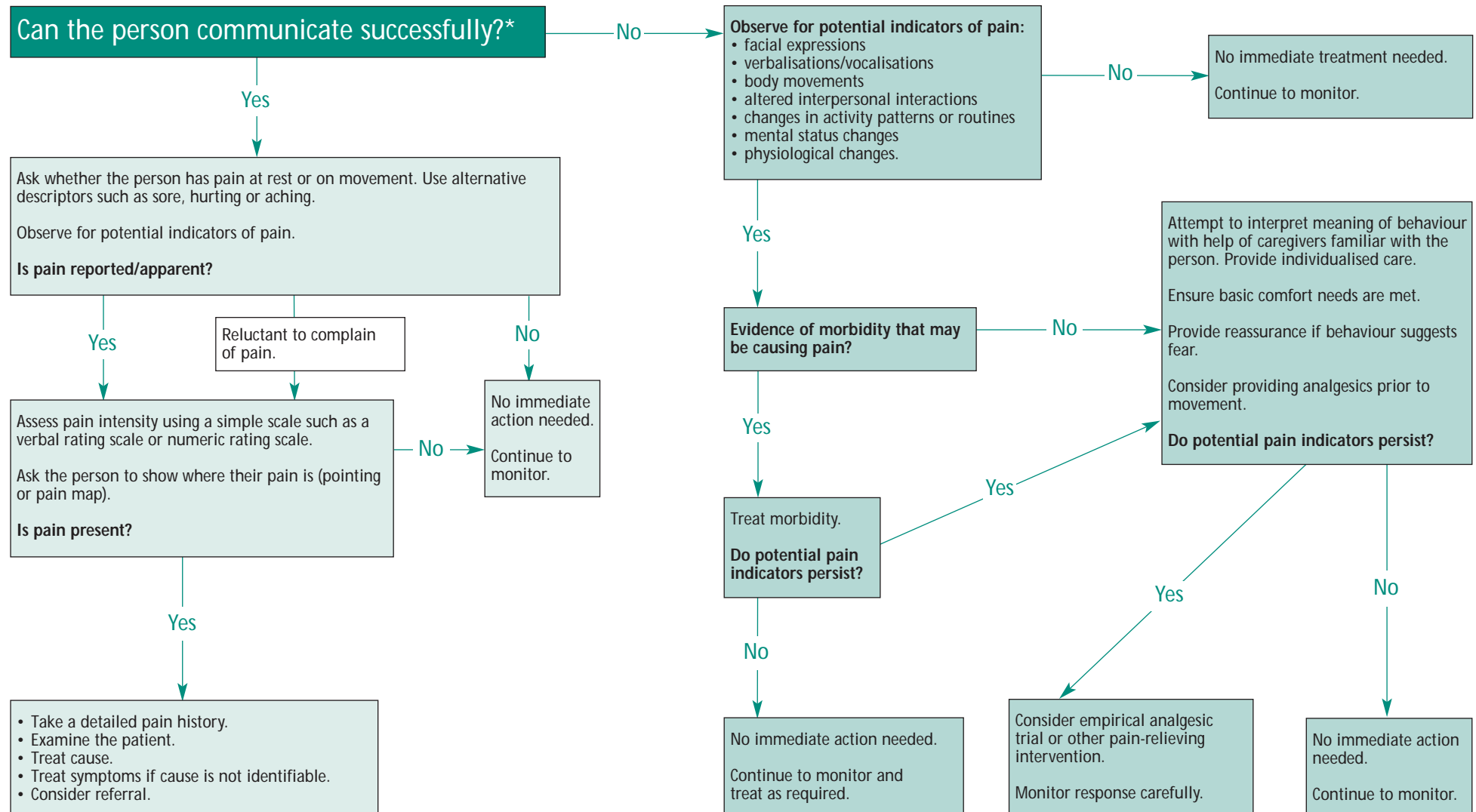
SUMMARY OF THE GUIDELINES

<i>Recommendation</i>	<i>Grade</i>	<i>Recommendation</i>	<i>Grade</i>
<p>1 Pain awareness</p> <p>All healthcare professionals should be alert to the possibility of pain in older people, and to the fact that older people are often reluctant to acknowledge and report pain.</p>	C	<p>4 Communication</p> <p>Every effort should be made to facilitate communication particularly with those people with sensory impairments (use of hearing aids, glasses etc).</p> <p>Self-report assessment scales should be offered in an accessible format to suit the strengths of the individual.</p>	C
<p>2 Pain enquiry</p> <p>Any health assessment should include enquiry about pain, using a range of alternative descriptors (eg sore, hurting, aching).</p>	C	<p>5 Assessment in people with impaired cognition/communication</p> <p>People with moderate to severe communication problems should be offered additional assistance with self-report through the use of suitably adapted scales and facilitation by skilled professionals.</p> <p>In people with very severe impairment, and in situations where procedures might cause pain, an observational assessment of pain behaviour is additionally required.</p> <p>Pain behaviours differ between individuals, so assessment should include insights from familiar carers and family members to interpret the meaning of their behaviours.</p>	C
<p>3 Pain description</p> <p>Where pain is present, a detailed clinical assessment of the multidimensional aspects of pain should be undertaken including:</p> <ul style="list-style-type: none"> • <i>sensory dimension</i>: the nature, location and intensity of pain • <i>affective dimension</i>: the emotional component and response to pain • <i>impact</i>: on functioning at the level of activities and participation. 	C	<p>6 Cause of pain</p> <p>Careful physical examination should be undertaken to identify any treatable causes. However, staff should be aware that pain can exist even if physical examination is normal.</p>	C
<p>3.1 Pain location</p> <p>An attempt to locate pain should be made by:</p> <ul style="list-style-type: none"> • asking the patient to point to the area on themselves • the use of pain maps to define the location and the extent of pain. 	C	<p>7 Re-evaluation</p> <p>Once a suitable scale has been identified, serial assessment should be undertaken using the same instrument to evaluate the effects of treatment.</p>	C
<p>3.2 Pain intensity</p> <p>Pain assessment should routinely include the use of a standardised intensity rating scale, preferably a simple verbal descriptor scale or a numeric rating scale, if the person is able to use these.</p>	C		

Source: Royal College of Physicians, British Geriatrics Society and British Pain Society. *The assessment of pain in older people: national guidelines*. Concise guidance to good practice series, No 8. London: RCP, 2007.

Algorithm for the assessment of pain in older people

CAN BE PHOTOCOPIED FOR STAFF USE



*If there is doubt about ability to communicate, assess and facilitate as indicated in Recommendations 4 and 5 of the Guidelines (overleaf).