General Guidelines

1. Determine if Mini Mental Status Examination scores are available or can be obtained. This would facilitate determination of patient ability to provide valid self-report

2. Always attempt self-report regardless of level of cognitive functioning

3. Baseline scores should be collected for each individual (ideally on a regular basis which would allow for the examination of unusual changes from the persons typical pattern of scores)

4. Patient history and physical examination results should be taken into consideration

5. If assessments are to be repeated over time, assessment conditions should be kept constant (e.g., use the same assessment tool, use the same assessor where possible and conduct pain assessment during similar situations)

6. Pain assessment results should be used to evaluate the efficacy of pain management interventions

7. Knowledgeable informants (e.g., caregivers) should be asked about typical pain behaviors of the individual

8. Other aspects of the pain experience should also be evaluated including environmental factors, psychological functioning and social environment

Recommendations Specific to Self-Report Measures

1. Use of synonyms when asking about the pain experience (e.g., hurt, aching) will facilitate the self-report of some patients who have limitations in ability to communicate verbally.

2. Self-report scales should be modified to account for any sensory deficits that occur with aging (e.g., poor vision, hearing difficulties)

3. Use self-report tools that have been found to be most valid among seniors (e.g., the Numeric Rating Scales, Verbal Rating Scales)

4. Use of horizontal visual analogue scales should be avoided as some investigators have found unusually high numbers of unscorable responses among seniors.

(Table 1 continues)

Recommendations Specific to Observational Measures
1. Observational tools that have been shown to be reliable and valid for use in this population include the PACSLAC and DOLOPLUS-2. Nonetheless, clinicians should always exercise caution when using these measures because they are relatively new and research is continuing.

2. When assessing pain in acute-care settings tools that primarily focus on evaluation of change over time should be avoided.

3. Observational assessments during movement-based tasks would be more likely to lead to the identification of underlying pain problems than assessments during rest

4. Some pain assessment tools, such as the PACSLAC, do not have specific cut off scores because of recognition of tremendous individual differences among people with severe dementia. Instead, it is recommended that pain is assessed on a regular basis (establishing baseline scores for each patient) with the clinician observing score changes over time.

5. Examination of pain assessment scores before and after the administration of analgesics is likely to facilitate pain assessment

6. Some of the symptoms of delirium (which is seen frequently in long-term care) overlap with certain behavioral manifestations of uncontrolled pain (e.g., behavioral disturbance). Clinicians assessing patients with delirium should be aware of this. On the positive side, delirium tends to be a transient state and pain assessment, which can be repeated or conducted when the patient is not delirious, is more likely to lead to valid results. It is important to note also that pain can cause delirium and clinicians should be astute in order to avoid missing pain problems among patients with delirium.

7. Observational pain assessment tools are screening instruments only and cannot be taken to represent definitive indicators of pain. Sometimes, they may suggest the presence of pain when pain is not present, and other times they may fail to identify pain.

Outcomes of Interest

In addition to improved scores on various assessment tools, evidence of more effective pain management can be observed in areas such as greater participation in activities, improved sleep, reduced behavioural disturbance, improved ability to ambulate, and improved social interactions.

Note: Many of these recommendations have been adapted from Hadjistavropoulos et al. (2007). Many of these recommendation also overlap with those of Herr et al. (2006). From Hadjistavropoulos, T. (2015). Pain assessment and management in older adults (in P. A. Lichtenberg and B. T. Mast (Eds). APA Handbook of Clinical Geropsychology (pp. 413-439). Washington: APA Press). Reproduced with permission.