

# Pain Assessment and Management Strategies for Elderly Patients

Home healthcare nurses play a critical role in pain assessment and management in elderly patients. People 65 years of age and older are the largest consumers of prescription and nonprescription pain medications in the United States and are at increased risk for adverse reactions and inadequate pain management. This article seeks to explore strategies to assist hospice and home healthcare nurses in assessing and managing elderly patients' pain. The goal is to provide tools to assist nurses in streamlining elderly patient care and improving quality of life while decreasing mortality and morbidity for this patient population.

**Robyn MacSorley, MSN, RN,  
Jill White, MSN, RN,  
Vicki H. Conerly, BSN, RN,  
Jean T. Walker, PhD, RN,  
Susan Lofton, PhD, RN, PHCNS/BC,  
Gaye Ragland, MSN, RNC,  
DeBrynda Davey, EdD, RN, CDVC,  
and Amy Robertson, MS**

**P**atients 65 years of age and older are the fastest growing age group in the country and are also the largest consumers of prescription and nonprescription pain medications in the United States (Hajjar et al., 2007). This dramatic increase in numbers of elderly patients consuming multiple pain medications makes the need for home healthcare nurses' assessment and intervention in pain management more critical than ever.

Hospice and home care patients who are affected by chronic and acute illnesses, and those who reside in nursing homes are at the highest risk for having serious complications related to pain medications. Many of these patients have multiple conditions such as heart disease, diabetes mellitus, cancer, arthritis, and other chronic illnesses, which are often treated with multiple types of pain medications (Hajjar et al., 2007). It is the use of pain medications coupled with the aging process that may create potential adverse effects in elderly patients.

Deeken et al. (2003) estimate that more than 50 million Americans serve as caregivers to homebound elderly adults. These caregivers are responsible for managing multiple pain medications for elderly patients often with very little understanding of potential adverse effects. Therefore, the teaching role of home healthcare nurses is vital to promote safety and quality of life in pain medication management.

This article seeks to explore strategies to assist hospice and home healthcare nurses in assessing and managing elderly patient pain medications. The goal is to provide tools to assist nurses to streamline elderly patient care and improve quality of life while decreasing mortality and morbidity for this patient population.



## Literature Review

### Pain and Pain Medications

Hajjar et al. (2007) state that multiple medical conditions such as cancer, diabetes, arthritis, and heart disease are the greatest pathological sources of pain for the elderly. These medical conditions cause acute, chronic nociceptive (somatic and visceral), and/or neuropathic pain. Elderly patients often have multiple sources, locations, and types of pain and are treated with standard opiates and other narcotics. Morphine, fentanyl, oxycodone, and hydromorphone are the most common opioids used to treat pain in the elderly, but these medications may also induce serious adverse effects.

Opioid use in the aged calls for concern regarding diminished renal and hepatic functions that may cause these medications to remain in the bloodstream for longer periods of time, resulting in adverse effects. This may also occur because opiate doses are prescribed in higher amounts or dosing frequencies than are tolerable for elderly patient pharmacokinetics. The most significant adverse effects of opioids in the elderly include respiratory depression, particularly with intravenous formulas, and cognitive changes with oral formulas, also as a result of altered pharmacokinetics (Maison, 2007). It is because of these kinetic changes that renal and hepatic function becomes compromised, which makes it difficult to predict the treatment response when opioid and other pain medications are used.

A significant concern noted with opioid treatment is delirium that can cause hallucinations and cognitive issues that can be seen especially when dementia or cerebrovascular injury is present (Lynch, 2011). These cognitive deficits, which can impair the patient's ability to communicate, require diligent assessment and intervention by the home healthcare nurse. This type of elderly patient may be unable to articulate feeling pain, so the pain may be manifested as increased agitation, anxiety, or functional decline in activities of daily living (Cavaliere, 2002; Dalacorte et al., 2011). The nurse must be diligent to assess for these changes and for other adverse effects of opiates in elderly patients that include dizziness, sedation, anxiety, insomnia, and gastrointestinal events (nausea, vomiting, diarrhea, and constipation).

Constipation is almost always associated with opioid use and may lead to further serious com-

plications such as impaction and bowel obstruction. Because elderly patients are already at risk for constipation it is essential to administer opioids along with a bowel program of laxatives, stool softeners, and dietary fiber to prevent such complications (Dalacorte et al., 2011; Hajjar et al., 2007). These complications can occur even with minimal opioid usage and that may cause additional problems for elderly patients.

In a review of the literature regarding pain management in the elderly, Dalacorte et al. (2011) identified several treatment options in the pharmacologic approach of consecutive use of analgesics and opioids during end-of-life care. The review results indicated statistical evidence that pain undertreatment in the elderly exists, especially in end-of-life care. The findings also strongly support inclusion of nonpharmacological treatment approaches that include: (a) physical therapies (massage, cold, heat, and electrophysical modalities), (b) exercise, (c) psychological therapies, and (d) complementary and alternative therapies. The authors recommended the use of pharmacological regimens that begin with weaker doses of opioids and then progress to stronger medications and doses as pain progresses or tolerance grows. This supports the maxim of "start low and go slow" in terms of elderly pain medication management.

In terms of neuropathic pain, which is known as "lancinating" (the worst of the worst), Dalacorte et al. (2011) noted that adults over 80 years of age have not been represented adequately in clinical trials. Based on the findings from the review they recommended that elderly patients with neuropathic pain might require opioids at a higher dose. They also suggest including nonpharmacological approaches to pain relief and the use of adjuvant drugs. The review authors also indicate that adjuvant drug therapy diminishes adverse effects from pain medications, increases pain relief, and treats psychological symptoms, thereby increasing quality of life (Dalacorte et al., 2011).

Musculoskeletal degeneration is also a significant source of pain for elderly patients. "Lumbar spinal stenosis is an extensive problem in older adults resulting in low back pain, disability, and depression" (Backstrom et al., 2011, p. 308), which puts the elderly at greater risks for falls, significant disabilities, and diminished quality of life. Caring for adults older than 65 years of age

with degenerative spine issues requires a plan of care to be formulated for pain management. The goal is promotion of independence for the patient and minimizing functional disability, thereby enhancing the quality of life (Vincent & Velkoff, 2010). When conservative treatments for the management of spinal stenosis such as nonsteroidal anti-inflammatory drugs (used cautiously in elderly due to risk of bleeding), activity modifications, and physical therapy are not effective, interventional approaches in the management of back pain may be an alternative. The use of minimally invasive procedures, such as epidural steroid injections (ESI), can provide a safe alternative for pain relief when there are substantial risks to the patient with surgical intervention (Friedly et al., 2012).

Home healthcare nursing knowledge of the patient's medical history and daily medications is essential information for the overall management of patient care with ESI. Notably, for elderly patients with diabetes, an increase in blood glucose levels is an expected response to ESI (Even et al., 2012). Patient and family education should include information that resolution to a preprocedure blood glucose range is expected within 2 days postinjection. After the ESI procedure, the home healthcare nurse should provide education to the patient outlining the most common side effects, which are an increase in hunger or thirst, frequent urination, blurry vision, and fatigue. Post-ESI procedure teaching includes possible need for adjustment in nutritional intake and insulin requirements, and the need for increased blood glucose monitoring during this period. Other assessments that should be monitored are the patient's temperature (as an elevation could indicate an infection), daily weights (to monitor for weight gain due to the steroids), and assessment of the injection site for bleeding and signs of infection.

### **Elderly Pain Assessment**

The assessment and measurement of pain in selected patient populations may require additional considerations for tool selection such as the need for the tool to be simply worded and easily understood (Flaherty, 2012). For instance, patients with a visual impairment may not be able to use a visual analog scale but would be able to self-report pain by using a verbal rating scale. Patients such as the elderly with cognitive

*Hospice and home care patients who are affected by chronic and acute illnesses, and those who reside in nursing homes are at the highest risk for having serious complications related to pain medications.*

communication disparities may need a simple self-report tool such as the Numeric Rating Scale (Acute Pain Management, 1992) or the Iowa Pain Thermometer Scale (Herr et al., 2007). Patients with moderate-to-severe cognitive impairments may benefit most from observational pain measurement scales. One such tool is the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC, see Appendix A; Fuchs-Lacelle & Hadjistavropoulos, 2004).

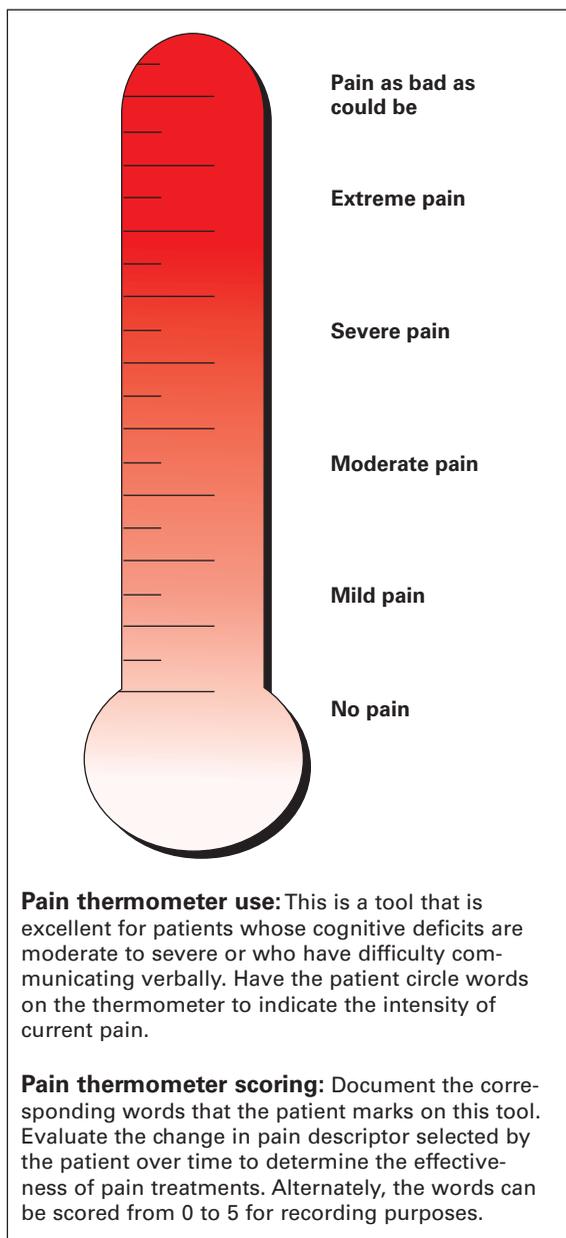
The Numeric Rating Scale is a commonly used pain rating scale in which individuals are asked to select a number between 0 and 10 that best reflects their current intensity of pain. Although the tool has been found to be a reliable and valid pain intensity measure, older adults, both with and without cognitive impairment, may have difficulty with the scale (Gagliese et al., 2005). The Iowa Pain Thermometer (Herr et al., 2007; see Figure 1) is a modified Descriptive Verbal Scale that provides the patient with a choice of seven pain descriptors illustrating different levels of pain intensity (no pain, slight pain, mild pain, moderate pain, severe pain, very severe pain, and the most intense pain imaginable). The patient is also allowed response options between words (scored from 0 to 12) all of which are aligned next to a pain thermometer. The patient is then shown the scale and is reminded about how temperature rises in a thermometer and is then asked to think of pain as increasing in the body as it rises to the top of the thermometer. The patient is then asked to identify their level of pain intensity. This tool may be used with patients who have moderate-to-severe cognitive impairments or who have difficulty communicating.

Observing pain behaviors is another avenue to assessing pain in elder patients with cognitive impairment or other difficulties communicating (Herr, 2011). The PACSLAC is a comprehensive tool that is commonly used to assess pain in people with dementia. Fuchs-Lacelle and Hadjstavropoulos (2004) interviewed professional long-term care providers of persons with dementia and identified items that are associated with

pain. In a later study, nurses were asked to complete the checklist of identified items as they related to patients with dementia who were under their care (Zwakhaleh et al., 2006). Sixty items were then organized into four categories of behaviors: (a) facial expressions; (b) activity and body movements; (c) social, personality, and mood; and (d) other, which included physiological, sleeping, eating changes, and vocalization changes. Each item is determined to be present or absent, after which subscores and a total score are calculated. The higher the total pain score, the greater the pain level. Assessing these pain behaviors is critical for effective, adequate, and sustained pain management in elderly patients. Without frequent pain assessments and effective interventions, undertreatment of pain may occur and contribute to needless suffering and diminished quality of life.

According to Pasero and McCaffery (2003), undertreatment of pain has been a concern for years, and in 2001 The Joint Commission on Accreditation of Health Care Organizations released pain management standards to address pain undertreatment. A comfort-function goal was eventually established to provide more clinician accountability for the relief of pain. These goals were specific to the client whether they were postoperative goals or hospice-specific goals to relieve a client's pain (Herr et al., 2010). The comfort-function goal is dependent on the use of pain rating scales that are specific to the population being served. It is important that the elderly client understands that scales are used to communicate his or her level of pain to the health-care provider, who in turn will establish and set goals toward pain relief and ongoing evaluation.

Elderly patient and family education by the home healthcare nurse needs to include a definition and descriptors of pain utilizing the PQRST method. The acronym includes the following essential elements: P: place (location of pain), Q: quality (stabbing, aching, sharp, dull, steady, and/or intermittent), R: radiation (does the pain spread anywhere?), S: severity (rate by influence of pain on physical activity, sleep, eating, and responses to medications), and T: timing (duration, frequency, how long each episode lasts, time of day that it is worse). Elderly patients accustomed to accurately describing pain parameters to their providers are more likely to have pain relief goals met (Mohamed et al., 2013).



**Figure 1. Pain Thermometer Scale.**  
Used with permission, Keela Herr, PhD, RN, FAAN, AGSF, University of Iowa, College of Nursing.

## Pain Diary

A pain diary is a substantial assessment tool for the home healthcare nurse to adequately assess patients' pain and their response to pain treatment. Numerous tools exist and can be easily located on the Internet and with Smart phone applications. The home healthcare nurse should provide education regarding the meaning and scoring of each element in the pain tool, and assess the patient and family preferences for recording in the pain diary.

The home healthcare nurse may explain to the patient that keeping records such as the pain diary makes it easier for the healthcare team to determine if the pain control plan is effective and what alleviates or aggravates pain. Such records also help the patient and caregiver to maintain medicine schedules that may also reduce pain levels. The nurse should instruct the patient and family to always take a copy of the pain diary to each physician visit, and to ensure that the home healthcare nurse reviews the diary during each visit. It is important to write any new medications or therapies that are added to the pain diary and to mark through those discontinued. This ensures the record remains accurate and current (Riker & Setter, 2013).

The authors developed a template (Appendix B) for the pain diary to help guide the home healthcare nurse with patient and caregiver education. Before the initial session, the home healthcare nurse should select a pain rating scale to be used in each visit, and ensure the patient has adequate copies or electronic access for daily use. The following steps will be useful for the home healthcare nurse working with the patient and caregivers in completing the pain diary:

1. Instruct on scoring and documentation in the diary. Discuss descriptors for intensity, duration, and words that describe how the pain actually feels.
2. Enter date and time of each pain event throughout each 24-hour period.
3. Instruct on how to document exactly where the pain is located (PQRST method).
4. List pain medications taken, including name and dosage of each medication.
5. Explain how to rate pain using the pain scale. Stress the importance of rating the pain when it occurs, and again 1 hour after the pain medication is taken.

*Opioid use in the aged calls for concern regarding diminished renal and hepatic functions that may cause these medications to remain in the bloodstream for longer periods of time, resulting in adverse effects.*

6. Instruct how to document adverse effects, and to note "no adverse effects" if none are experienced.
7. Remind the patient and caregiver of non-pharmacological measures for treatment of pain, such as deep breathing, massage, music, and so on. Instruct them on where and how to document them and their effectiveness.
8. Explain the risk of constipation and the importance of documenting frequency, type, and size of bowel movements. If medication is taken, note the type, amount, and results.
9. Encourage the patient and caregiver to document anything else they believe to affect pain positively or negatively like visitors, food, positioning, and so on.

Reinforcement of principles and elements of the pain diary for the patient and caregiver should be ongoing. If the patient and caregiver are unable to maintain the diary, the home healthcare nurse and staff may need to complete it for the patient during each visit. It is important to note that the dynamics of family and caregiver roles greatly impact elderly patient pain management.

## Family and Caregiver Dynamics

The population of older adults being cared for at home by family members is on the rise. According to Deeken et al. (2003), more people are living longer, many times with chronic and debilitating illnesses resulting in changing family dynamics. The changing family dynamics may result in financial, physiological, and psychological strain

on caregivers. The quality of life for both the patient and caregiver can be profoundly affected if the caregiver has unmet needs or is experiencing a high level of burden. In working with elderly home care patients, the hospice or home health-care nurse has the advantage to see first-hand the stress, burden, and potential problems the caregiver is experiencing. Caring for an elderly family member experiencing pain along with managing pain medications and other medications may provide an enormous level of stress.

The World Health Organization (2011) listed a primary objective of palliative care to address the needs of family caregivers. Many self-report instruments have been developed to measure the caregiver's burden, needs, and their quality-of-life. The scales recommended by Deeken et al. (2003) included two burden scales: (a) the Given and Given's Caregiver Reaction Assessment and (b) the Bakas' Caregiving Scale. These two were recommended because of validity and reliability. Caregivers' quality of life is now recognized as a vital outcome for health-related interventions for patients' quality of life (Deeken et al., 2003).

Quality of life instruments for patients recommended by Deeken et al. (2003) were the (a) Ferrell's Quality of Life Tool, due to it being in-depth and because of the psychometric testing design and (b) the Weiner's Quality-of-Life Index-Cancer due to its rigorous development in the new cancer patient and family caregiver groups. According to Deeken et al. (2003), changes in healthcare are influencing the fact that more chronically ill patients are being cared for at home. Healthcare professionals must be mindful that the patients' caregivers are a vital part of the patient's healthcare team, and without support and sometimes intervention they have the potential to become patients themselves. The home healthcare nurse must be vigilant in observing the caregiver(s) and know when and how to assist them from becoming overly burdened.

The home healthcare nurse supports caregivers by teaching them how to effectively use the tools for assessing pain and communicating those results. Teaching and reinforcing the use of helpful, appropriate tools related to disease processes, pain, and pain management strategies serve to increase patients' and caregivers' sense of control. This control enhances caregiver quality of life as they collaborate with healthcare providers to provide care for their loved one.

- Explain to family members how to use the appropriate tools that are available for assessing pain and communication.
- Set up meetings and conferences with family members to discuss progress of loved ones.
- Assess the family member's level of stress.
- Determine what concerns the family members have about their loved ones.
- Assess the patient's medication administration needs with family caregivers, when appropriate.

**Figure 2.** Ways the home healthcare nurse assists family members.

They may be more able to express their concerns and assess their own needs as part of the care team (Figure 2).

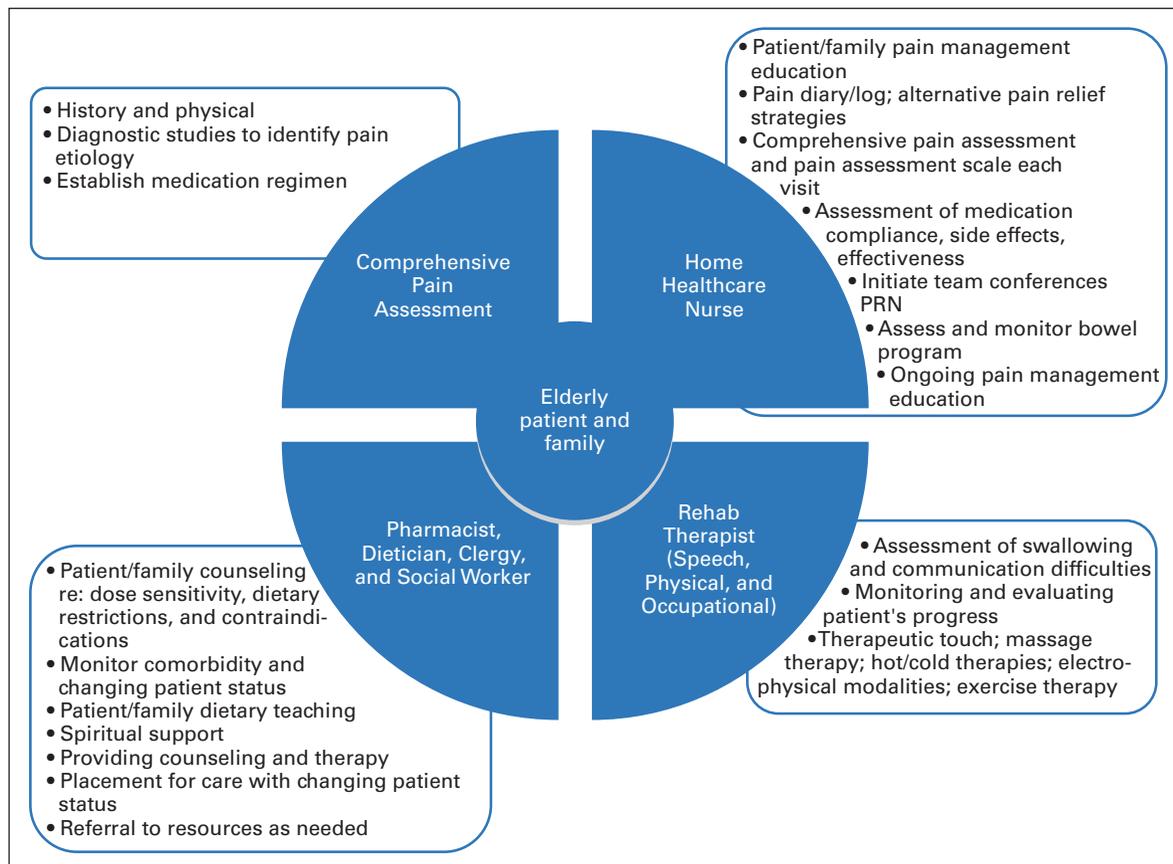
### Strategies for Successful Nursing Care The Interdisciplinary Team

Caring for elderly patients receiving pain medications requires the home healthcare nurse to integrate the primary care provider and all disciplines involved in the patient's ongoing care. "Team-based healthcare is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care" (Mitchell et al., 2012, p. 5).

For team-based healthcare to be successful, it is important to have adequate communication among all involved in care, maintain purposeful team collaboration, and provide the best evidence-based practices. Healthcare provided by a well-developed team approach empirically demonstrates positive patient outcomes, more efficient care, and patient and professional satisfaction (Mitchell et al., 2012). Shared goals require the whole team, including the patient, family, or other caregiver all working together toward establishing, understanding, and following through on well-founded goals supported by all involved. Each team member's functions, responsibilities, and accountability should be clearly articulated. Having a clear understanding and expectations of each role improves the team's efficiency.

#### MacSorley Communication Model: Elderly Pain

The home healthcare nurse is in a vital position to determine the patient's response to pain and



**Figure 3.** Communication Model—Elderly Pain.

Note. PRN = as needed.

to treatment. The team approach is used when the home healthcare nurse visits the patient, performs a health assessment, reviews medications, and determines the need for a comprehensive pain assessment due to the patient's status and pain medication usage. From this assessment a determination is made of the need for collaborative care partners to become involved. Collaborative care may include a: (a) primary healthcare provider, (b) home healthcare nurse, (c) pharmacist, (d) dietitian, (e) clergy (or spiritual leader), (f) social worker, and (g) rehabilitation therapist.

The MacSorley Communication Model: Elderly Pain Model (Figure 3) has been developed as a comprehensive model for providing home healthcare nurses with a means of caring for the elderly patient and their family while communicating their needs to the interdisciplinary healthcare team. With the advancement of technology there are multiple means of providing and transmitting communication. Some means are: (a) telemedi-

cine, (b) smart phone, and (c) voice over Internet protocol and instant messaging client. Telemedicine involves telemonitoring the patient from a remote location. It allows the interdisciplinary healthcare team to provide remote visualization, supervision, and transmission of recorded data to determine what further education and care is needed for the patient and family. Regardless of the method, it is important to maintain patient confidentiality when using these alternatives. The following bullet points are meant to help guide the home healthcare nurse when providing care to the patient and communicating potential problems to the interdisciplinary healthcare team.

- Providing a comprehensive pain assessment, which consists of:
  - o obtaining a history and physical;
  - o determining pain etiology through diagnostic studies; and
  - o establishing a medication regimen.

- Maintaining the home healthcare nurse's role by:
  - o providing pain management education for the patient and the family/caregiver;
  - o keeping up with a pain diary/log;
  - o performing a comprehensive pain assessment and pain assessment scale each visit;
  - o assessing for medication compliance, adverse effects, and medication effectiveness;
  - o initiating team conferences as needed; assess and monitor bowel function; and
  - o providing ongoing pain management education.
- The involvement of a pharmacist, dietitian, clergy and social worker (interdisciplinary healthcare team) and their role by:
  - o providing patient and family counseling regarding dose sensitivity, dietary restrictions, and contraindications between medications and/or food (pharmacist/dietitian);
  - o monitoring comorbidity and changing patient status (pharmacist/dietitian);
  - o providing patient and family dietary teaching (dietitian);
  - o providing spiritual support (clergy);
  - o providing counseling and therapy (dietitian/social worker);
  - o placement for care with changing patient status (social worker); and
  - o referral to resources as needed (social worker).
- The involvement of the rehabilitation therapist's (speech, physical therapist and occupational therapist) interdisciplinary healthcare teams role by:
  - o providing services such as assessment of swallowing and communication difficulties; monitoring and evaluating patient's progress; therapeutic touch; massage therapy; hot/cold therapies; electrophysical modalities; and exercise therapy.

## Summary

Home healthcare nurses play a pivotal role in community care settings caring for elderly patients with complex healthcare issues, such as pain management. Nurses serve as patient advocates and coordinators of extensive collaborative care. Hopefully, with the strategies set forth in this article, the home healthcare nurse may more effectively intervene with and on behalf of elderly patients who experience pain. The goal is to communicate effectively within the healthcare team in an effort to provide

*Observing pain behaviors is another avenue to assessing pain in elder patients with cognitive impairment or other difficulties communicating.*

quality and efficient care. The final outcome of this care is focused on improving the quality of life for elderly patients and families, which in turn will decrease suffering, mortality, and morbidity. ■

**Robyn MacSorley, MSN, RN**, is an Instructor, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

**Jill White, MSN, RN**, is an Assistant Professor, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

**Vicki H. Conerly, BSN, RN**, is in Senior Management, Woman's Hospital, Flowood, Mississippi.

**Jean T. Walker, PhD, RN**, is a Professor, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

**Susan Lofton, PhD, RN, PHCNS/BC**, is a Professor, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

**Gaye Ragland, MSN, RNC**, is an Associate Professor, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

**DeBrynda Davey, EdD, RN, CDVC**, is a Professor, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

**Amy Robertson, MS Instructional Technology**, is a Graphic Designer, School of Nursing, University of Mississippi Medical Center, Jackson, Mississippi.

The authors and planners have disclosed no potential conflicts of interest, financial or otherwise.

Address for correspondence: Robyn MacSorley, MSN, RN, School of Nursing, University of Mississippi Medical Center, 2500 North State St., Jackson, MS 39216 (rmacsorley@umc.edu).

DOI:10.1097/NHH.0000000000000065

## REFERENCES

- Acute Pain Management. (February 1992). *Operative or Medical Procedures and Trauma, Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032* (pp. 116-117). Rockville, MD: Agency for Healthcare

- Research & Quality. Retrieved from <http://archive.ahrq.gov/clinic/medtep/acute.htm>
- Backstrom, K. M., Whitman, J. M., & Flynn, T. W. (2011). Lumbar spinal stenosis-diagnosis and management of the aging spine. *Manual Therapy, 16*(4), 308-317.
- Cavalieri, T. A. (2002). Pain management in the elderly. *Journal of the American Osteopathic Association, 102*(9), 481-485.
- Dalacorte, R. R., Rigo, J. C., & Dalacorte, A. (2011). Pain management in the elderly at the end of life. *North American Journal of Medical Sciences, 3*(8), 348-354.
- Deeken, J. F., Taylor, K. L., Mangan, P., Yabroff, K. R., & Ingham, J. M. (2003). Care for the caregivers: A review of self-report instruments developed to measure the burden, needs, and quality of life of informal caregivers. *Journal of Pain and Symptom Management, 26*(4), 922-953.
- Even, J. L., Crosby, C. G., Song, Y., McGirt, M. J., & Devin, C. J. (2012). Effects of epidural steroid injections on blood glucose levels in patients with diabetes mellitus. *Spine, 37*(1), E46-E50. doi:10.1097/BRS.0b013e31821fd21f
- Flaherty, E. (2012). Pain assessment for older adults. In *Try This: Best Practices in Nursing Care to Older Adults, Vol. 7* (pp. 1-2). The Hartford Institute for Geriatric Nursing, College of Nursing, New York University, New York City, NY.
- Friedly, J. L., Bresnahan, B. W., Comstock, B., Turner, J. A., Deyo, R. A., Sullivan, S. D., ..., Jarvik, J. G. (2012). Study protocol—Lumbar Epidural steroid injections for Spinal Stenosis (LESS): A double-blind randomized controlled trial of epidural steroid injections for lumbar spinal stenosis among older adults. *BMC Musculoskeletal Disorders, 13*, 48. doi:10.1186/1471-2474-13-48
- Fuchs-Lacelle, S., & Hadjistavropoulos, T. (2004). Development and preliminary validation of the pain assessment checklist for seniors with limited ability to communicate (PACSLAC). *Pain Management Nursing, 5*(1), 37-49.
- Gagliese, L., Weizblit, N., Ellis, W., & Chan, V. W. (2005). The measurement of postoperative pain: A comparison of intensity scales in younger and older surgical patients. *Pain, 117*(3), 412-420.
- Hajjar, E. R., Cafiero, A. C., & Hanlon, J. T. (2007). Polypharmacy in elderly patients. *American Journal of Geriatric Pharmacotherapy, 5*(4), 345-351.
- Herr, K. (2011). Pain assessment strategies in older patients. *Journal of Pain, 12*(3 Suppl. 1), S3-S13.
- Herr, K., Spratt, K. F., Garand, L., & Li, L. (2007). Evaluation of the Iowa pain thermometer and other selected pain intensity scales in younger and older adult cohorts using controlled clinical pain: A preliminary study. *Pain Medicine, 8*(7), 585-600.
- Herr, K., Titler, M., Fine, P., Sanders, S., Cavanaugh, J., Swegle, J., ..., Tang, X. (2010). Assessing and treating pain in hospices: Current state of evidence-based practices. *Journal of Pain and Symptom Management, 39*(5), 803-819.
- Lynch, T. (2011). Management of drug-drug interactions: Considerations for special populations: Focus on opioid use in the elderly and long term care. *American Journal of Managed Care, 17*(Suppl. 11), S293-S298.
- Maison, D. (2007). A hospice physician's perspective on medications for the relief of pain and suffering. *Home Healthcare Nurse, 25*(10), 663-670.
- Mitchell, P., Wynia, M., Golden, R., McNellis, B., Okun, S., Webb, C. E., ..., Von Kohorn, I. (2012). Core principles & values of effective team-based health care. Retrieved from <http://217ewmp01.blackmesh.com/~media/Files/Perspectives-Files/2012/Discussion-papers/VSRT-Team-Based-Care-Principles-Values.pdf>
- Mohamed, M., Ahamed, A., & Mahmoud, M. (2013). Application of a proposed graphic chart for pain as fifth vital sign in nursing practice at Assiut University Hospital. *Journal of American Science, 9*(4), 197-201.
- Pasero, C., & McCaffery, M. (2003). Accountability for pain relief: Use of comfort-function goals. *Journal of PeriAnesthesia Nursing, 18*(1), 50-52.
- Riker, G. I., & Setter, S. M. (2013). Polypharmacy in older adults at home: What it is and what to do about it-implications for home healthcare and hospice, part 2. *Home Healthcare Nurse, 31*(2), 65-77.
- Vincent, G. K., & Velkoff, V. A. (2010). The next four decades: The older population in the United States: 2010-2050. Retrieved from <http://www.census.gov/prod/2010pubs/p25-1138.pdf>
- World Health Organization. (2011). Palliative care for older people: Better practices. Retrieved from [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0017/143153/e95052.pdf](http://www.euro.who.int/__data/assets/pdf_file/0017/143153/e95052.pdf)
- Zwakhalen, S. M., Hamers, J. P., Abu-Saad, H. H., & Berger, M. P. (2006). Pain in elderly people with severe dementia: A systematic review of behavioral pain assessment tools. *BMC Geriatrics, 6*, 3. Retrieved from <http://www.biomedcentral.com/1471-2318/6/3>

For more than 50 additional continuing nursing education activities about pain management, go to [nursingcenter.com/ce](http://nursingcenter.com/ce)



Facial Expressions	Present
Grimacing	
Sad look	
Tighter face	
Dirty look	
Change in eyes (squinting, dull, bright, increased movement)	
Frowning	
Pain expression	
Grim face	
Clenching teeth	
Wincing	
Opening mouth	
Creasing forehead	
Screwing up nose	
Activity/Body Movement	
Fidgeting	
Pulling away	
Flinching	
Restless	
Pacing	
Wandering	
Trying to leave	
Refusing to move	
Thrashing	
Decreased activity	
Refusing medications	
Moving slow	
Impulsive behavior (e.g., repetitive movements)	

Activity/Body Movement	Present
Uncooperative/resistant to care	
Guarding sore area	
Touching/holding sore area	
Limping	
Clenched fist	
Going into fetal position	
Stiff/rigid	
Social/Personality/Mood	
Physical aggression (e.g., pushing people and/or objects, scratching others, hitting others, striking, kicking)	
Verbal aggression	
Not wanting to be touched	
Not allowing people near	
Angry/mad	
Throwing things	
Increased confusion	
Anxious	
Upset	
Agitated	
Cranky/irritable	
Frustrated	
Other*	
Pale face	
Flushed, red face	
Teary eyed	
Sweating	

Other (continued)	Present
Shaking/trembling	
Cold and clammy	
Changes in sleep (please circle): Decreased sleep or increased sleep during day	
Changes in appetite (please circle): Decreased appetite or increased appetite	
Screaming/yelling	
Calling out (i.e., for help)	
Crying	
A specific sound or vocalization for pain "ow," "ouch"	
Moaning and groaning	
Mumbling	
Grunting	

Subscale scores:

Facial expressions \_\_\_\_\_

Activity/body movement \_\_\_\_\_

Social/personality mood \_\_\_\_\_

Other \_\_\_\_\_

**Total checklist score** \_\_\_\_\_

\*\*"Other" subscale includes physiological changes, eating and sleeping changes, and vocal behaviors.

This version of the scale does not include the items "sitting and rocking," "quiet/withdrawn," and "vacant blank stare" as these were not found to be useful in discriminating pain from nonpain states.

Copyright © Shannon Fuchs-Lacelle and Thomas Hadjistavropoulos. (The PACSLAC is distributed with the permission of the copyright holders.)

The PACSLAC may not be reproduced without permission. For permission to reproduce the PACSLAC contact the worldwide copyright holder's thomas.hadjistavropoulos@uregina.ca.

THE DEVELOPERS OF THE PACSLAC SPECIFICALLY DISCLAIM ANY AND ALL LIABILITY ARISING DIRECTLY OR INDIRECTLY FOR USE OR APPLICATION OF THE PACSLAC. USE OF THE PACSLAC MAY NOT BE APPROPRIATE FOR SOME PATIENTS AND THE PACSLAC IS NOT A SUBSTITUTE FOR A THOROUGH ASSESSMENT OF THE PATIENT BY A QUALIFIED HEALTHCARE PROFESSIONAL. The PACSLAC (like all other related observational tools for seniors with dementia) is a screening tool and not a definitive indicator of pain. As such, sometimes it may incorrectly signal the presence of pain and, other times, it may fail to identify pain. As such, it should be used by qualified healthcare staff within the context of their broader knowledge and examination of the patient.

## Appendix B. Pain Diary

Pain Diary: Daily

Date: \_\_\_\_\_

Time	Pain Location	Pain Rating Quality	Pain Medications Taken and Amount	Relief Pain Rating 1 Hour After Meds	Adverse Effects	Other Measures Taken	Bowel Movements	Comments
12 AM								
1 AM								
2 AM								
3 AM								
4 AM								
5 AM								
6 AM								
7 AM								
8 AM								
9 AM								
10 AM								
11 AM								
12 PM								
1 PM								
2 PM								
3 PM								
4 PM								
5 PM								
6 PM								
7 PM								
8 PM								
9 PM								
10 PM								
11 PM								
		<i>throbbing stabbing burning aching constant intervals</i>			<i>nausea vomiting diarrhea constipation headache dizziness rash</i>		<i>number quality consistency</i>	

Developed by authors from CBK

Rating scale: 0  $\longleftrightarrow$  10  
 Not much pain worst pain

List all medications:

### Instructions for use

1. Complete one page daily.
2. Make sure your home healthcare nurse sees your pain diaries every week.
3. Take a copy of these to your primary care provider visits as well.