NHPCO is pleased to share the following article to help inform the work of hospice and palliative care professionals. It is one of many timely articles which have been reviewed and approved by the NHPCO Quality and Standards Committee for dissemination. (To review and/or download all articles, visit the Quality Updates and Resources webpage of the NHPCO website.)

**Article Title: Pain Assessment in Nonverbal Hospice Patients**  
**By: Ronalda Dick MSN**

Pain Assessment in Nonverbal Hospice Patients August 2011 heralded publication of CMS’s final rule which included the first ever public reporting requirements for hospice providers. National Quality Forum’s measure # 0209 for outcome related to comfort due to pain 48 hours after admission is known to many hospice providers as one of NHPCO’s End Result Outcome Measures (EROMs). As a performance measure which quantifies perception of pain by patients able to verbally self report, both at time of admission and 48 hours later, this comfortable dying indicator is one of a very few number of hospice measures which has been scrutinized over a number of years. As such, it has now been chosen by CMS as a logical starting point for public reporting.

The research literature has taught us the clinical definition of “pain is whatever the experiencing person says it is…” (McCaffery, 1968). In hospice practice, however, the patient often cannot “say” and the toolbox we can rely upon for reliable assessment of pain in large numbers of nonverbal patients is largely untested. The final rule which now gives us our first direction also conveys the scarcity of research related specifically to EOL care and symptom management. But the wealth of research related to pain in general and clinical practice recommendations which currently do exist for assessment of pain in nonverbal patients can move us forward towards more clinically valid and reliable measures, something practitioners of quality hospice care will certainly welcome.

One such clinical practice recommendation from the American Society for Pain Management (ASPM) for pain assessment in the nonverbal patient (retrieved from www.medscape.com July 2011) reminds us that “no single objective assessment strategy...is sufficient by itself.” However, this set of recommendations for nonverbal pain assessment does provide general advice from the hierarchy of pain assessment techniques proposed by McCaffery & Pasero (1999) along with some more specific advice for groups of selected populations of patients of specific interest to hospice providers, including elders with dementia.
The ASPM’s general clinical recommendations advise attempts at pain assessment via self report as the first choice for all patients, including dementia patients with mild to moderate cognitive impairment. A nonverbal self report is the next best available assessment technique for those patients who may be able to provide some vocalization other than speaking, such as credible grunting, head nods, finger spans, or blinking eyes to answer yes or no. Pointing to specific points on visual tools such as a pain thermometer or ESAS-r scale (Edmonton Symptom Assessment System –revised) could be another method of nonverbal self reporting.

As dementia patients progress to an advanced stage, even nonverbal self report is no longer possible. Providers now need to place reliance upon a combination of observational (behavioral) assessment techniques and surrogate (family, caregiver, or health professional) report of estimation of pain. Although less reliable, it’s the next best alternative.

In determining if surrogate reporting is credible, we must take into account the consistency and the length of the relationship, caregiving or otherwise, with the patient. “Familiarity with the patient and knowledge of usual and past behaviors...that may be indicators of pain presence” is the most important factor to consider (retrieved from www.Medscape.com July 2011). In other words, we need to encourage those knowledgeable and close to the patient to become involved in assessment of pain by communicating to us, as hospice staff, known behaviors that may be indicative of pain. Several of the published tools for nonverbal pain assessment included in CMS’s Hospice PEACE and AIM Projects as having the most potential for the hospice population are also mentioned specifically in ASPM’s clinical recommendations as having the strongest psychometric support at the present time for use with elder dementia patients. These include, along with others, the CNPI: Checklist of Nonverbal Pain Indicators (Feldt et al) and the PAINAD: Pain in Advanced Dementia Scale. The seemingly strongest statement made in my review of clinical recommendations related to pain assessment is that no “institutionalization’ regarding use of any one tool should occur. In other words, the best tool for one patient will not necessarily be the best tool for the next patient.

This statement is of particular importance for hospices using software documentation systems whose vendors may be promoting one specific tool or scale for inclusion in their product. This decision may be based on the ability to “sweep” data and not on which tool will provide the most accurate assessment for any particular patient. This could lead to a systematic process of inaccurate pain assessments. For example, an experienced and knowledgeable practitioner would not choose to use a behavioral (observational) tool for a stroke patient who is flaccid and unable to respond behaviorally.

As hospices and practitioners concerned for the accuracy of our pain assessments, we would be wise to include the research based hierarchy of pain assessment techniques included in the ASPM clinical recommendations by Pasero & McCaffery (2005) in orientation and training for our staffs and in our infrastructures of procedures, processes, or protocols. A template for this infrastructure formed by the clinical recommendation hierarchy for pain assessments (Pasero &
McCaffery 2005), along with additional general hospice knowledge, might look something like the following:

1. Attempt to first elicit a self report from patient and, if self report cannot be used, explain why (remember nonverbal self report can also be a credible self report. The PEACE and AIM projects have provided us with multiple tools which will accommodate nonverbal responses).

2. Identify pathological conditions or procedures that may cause pain (In hospice, we are taught to identify positioning, wounds, constipation, infections, disease process, etc. as the conditions to be assessed/investigated with various types of pain interventions).

3. List patient behaviors that may indicate pain. Share this information with IDT members and include in care plans and updates. Behavioral/observational assessment scales/tools may be used.

4. Identify behaviors that caregivers and others knowledgeable about the patient think may indicate pain and include these in information shared with the IDT as well.

5. Attempt an analgesic trial per physician/NP order or approved order sets, remembering that response or lack of response to analgesics is often the clue that we have correctly or incorrectly assessed the pain of nonverbal patients.

Patient outcomes for our nonverbal patients should benefit from such an approach.