Overcoming Barriers to Pain Assessment: Communicating Pain Information with Intubated Older Adults

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Previously in this column, Monroe and Mion [3] discussed the challenges in pain assessment for patients with advanced dementia and offered recommendations regarding the use of well-validated behavioral pain assessment tools for persons with advanced dementia. Older adults who are mechanically ventilated face obstacles that are similar to those faced by patients with dementia when communicating about their pain. While negative vocalizations may be the best indication of pain in the cognitively impaired older adult, mechanically ventilated (MV) patients cannot vocalize about their pain at all. Mrs. Jones' case shows that if awake and responsive, older adults receiving MV can engage in reliable communication about their pain. This is true even for those who also experience mild sedation or delirium during MV. We take the approach that patient self-report is the gold standard for pain assessment.[4] As such, attempts to elicit the MV patient's pain report are the first step before resorting to the use of behavioral pain tools [5].

In our review of patient clinical records, we've noticed the relatively frequent use of the standardized phrase "unable to communicate/ unable to assess pain." For example, this automated response phrase was assigned to pain assessments in the electronic health record for 30% (56/184) of MV patients randomly selected from 6 different ICUs who had at least 12-hrs of sustained wakefulness. Pain reports and pain ratings were followed for a maximum of 28 ICU days [6]. This preliminary finding points to the need for better assessment and facilitation of pain communication among nonvocal MV patients.

Several standardized visual pain intensity assessment tools, the Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS) and the Faces Pain Scale-Revised (FPS-R), can be used to assess pain in acute/critically ill older adults who are alert and unable to speak [7]. In this article, we present three primary strategies to assess pain for patients who are

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awake, alert and without ability to communicate through vocalization because of MV. We used these assistive communication strategies successfully with nurses and older MV patients during the SPEACS and SPEACS-2 studies. [8,9] The purpose is to improve the accuracy of pain assessment and communication by compensating for the MV patient's physical and/or cognitive limitations.

1. Establishing a reliable YES-NO signal

Patients who are able to signal a clear YES or NO response should be able to answer a direct question about pain. If the patient is too weak to use head nods, other possible YES-NO signals include thumbs up or down, or eye blinks. [10] The most important component to individualizing YES-NO signals is communicating to others what the signal is. This can be accomplished by mounting a written communication plan on the bedside wall or incorporating communication strategies into the care plan that is shared with other caregivers during shift hand-offs.[9]

2. Communication Boards

Communication boards come in all shapes and sizes. Picture boards with word labels can be especially useful with patients who have cognitive impairment. Alphabet boards are arrangements of letters usually in alphabetical or QWERTY keyboard order. Patients spell words, phrases or whole messages by pointing. Communication boards designed specifically for communicating medical needs may include a body diagram and/or pain intensity rating scale [11] The nonvocal patient can indicate the location of their pain by pointing to the pain site or to the location on a body picture. If the patient is unable to point and a reliable YES-NO signal is established, the nurse can assist by pointing to locations on a body picture while the patient confirms (using YES-NO) the pain location. [10] Pain intensity can be communicated nonvocally by gesture (the patient holds up fingers to indicate a numerical rating), pointing to a level on a visual pain scale (e.g., Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS) or the Faces Pain Scale-Revised (FPS-R)), or by signaling YES-NO as the nurse points to the appropriate level on a pain scale. Mrs. Jones and her nurse used the assisted pointing technique with the FPS-R to obtain a pain assessment rating.

3. Lip reading

Patients who are being ventilated via tracheostomy often rely on others to lip read as they silently mouth words to communicate. This method can be misinterpreted if the patient articulates poorly or "speaks" rapidly. You can see how easily this might happen by mouthing "pants" and "pain" silently. The MV patient who repeatedly received pain medicine when he was requesting pants taught us this lesson [12]. Nurses can facilitate lip reading by using the following techniques:

- Maintain eye contact

- Encourage the patient to speak slowly, using lips, teeth and tongue and to over-articulate the words.

- Insert dentures if available.

If misunderstanding persists, first-letter spelling is a strategy that combines use of a letter board with patient mouthing. The patient indicates the first letter of the word that they are trying to communicate on an alphabet board; then, slowly "speaks" the word. [13, 14]

None of the aforementioned techniques will be successful if the patient does not understand or cannot attend to the nurse's question(s) about pain. Acute and critically ill older adults

often experience delayed processing or response time, extreme fatigue, or the inability to attend to a conversation or task. Techniques to increase patient understanding include:

- Wait for a response and resist asking additional questions.

- Add visual input such as pictures (e.g., body diagram), written key words, or a pain scale as you talk.

- "Tag" the end of a question with response choices.

The tagged YES-NO technique is a simple verbal technique to anchor a question with response choices while modeling the YES-NO signal (e.g.," Are you having pain? Yes? [nodding head] Or no? [shaking head side to side]"). [15] This is useful to maintain focus with patients who are mildly confused or sedated.

If the patient is too highly sedated or fatigued and efforts to establish a clear YES-NO signal are unsuccessful, a behavioral pain scale should be used. Unlike the behavioral pain scales for patients with advanced dementia [3], the Critical-Care Pain Observation Tool (C-POT) [16, 17] or Behavioral Pain Scale (BPS) [18] facilitate assessment of pain in nonvocal ICU patients, such as those receiving MV.

On a systems level, nurse managers, unit leaders, and clinical nurse specialists can facilitate good quality assessment practices by incorporating necessary components into nursing education, documentation tools and the patient environment. Unit-based education on pain assessment, which includes information on behavioral pain scale use *and is tailored to the specific needs of the unit's patient population*, should be developed. The case study with Mrs. Jones illustrates how two different assessment techniques were used, based on the needs of the patient at different points in her recovery trajectory. For units where the staff is unfamiliar with the use of assistive communication strategies, enlist the support of speech language pathology (SLP) staff to model communication techniques and institute regular interdisciplinary communication rounds [9].

When unable to document a patient-provided pain rating, the electronic documentation system should automatically prompt the nurse to assess and document the patient's pain status using the appropriate behavioral pain scale. This will involve selection and system-wide adoption of pain assessment tools in the electronic health record. Unit leadership can perform audits to evaluate the use of "unable to assess" responses in nursing documentation and target the unit-specific needs for education to improve practice in pain assessment and pain communication.

Acknowledgments

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Case Study

Mrs. Jones is a 67-year old woman admitted to the ICU with complications following head and neck cancer surgery. She is mechanically ventilated via tracheotomy tube and was heavily sedated post-operatively for severe agitation. Because Mrs. Jones was unable to respond to queries about pain, the ICU nurses used a behavioral pain scale specifically geared to MV patients that incorporated ventilator synchrony and behavioral pain indicators in place of breathing and vocalization [1]. This morning, Mrs. Jones is calm and alert, squeezing the doctor's hand for the first time in response to a question. Her nurse consults the speech language pathologist (SLP) for assistance in assessing and planning communication with Mrs. Jones. The nurse is particularly interested in accurately assessing and managing Mrs. Jones' pain to disrupt the pain-agitation-sedation cycle. The SLP finds that Mrs. Jones is awake and oriented to person only. She is able to nod YES and NO slightly and consistently. Mrs. Jones is extremely weak but can follow commands to wiggle her fingers, blink her eyes twice, and look at pictures on a communication board. Her hands are tremulous and her arms are weak. She is unable to point to a picture, gesture effectively, or hold a pen to write. Mrs. Jones indicates that she is in pain by nodding "yes" in response to a direct question. The SLP and nurse use these communication assessment findings to obtain information about the location and intensity of her pain Using the assisted pointing technique (the nurse systematically points to areas on a drawing of a body), Mrs. Jones endorses pain in her head, neck and chest, but denies pain in her arms, legs and back. Mrs. Jones watches intently as the nurse points to each level on the Faces Pain Scale-Revised [2] finally indicating a pain level of 10/10 by nodding "YES".