



Pain Assessment in the Non-verbal Patient Position Statement with Clinical Practice Recommendations

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Position Statement with Clinical Practice Recommendations: Pain Assessment in the Non-verbal Patient

Background:

Pain is a subjective experience, and no objective tests exist to measure it (APS, 2003). Whenever possible the existence and intensity of pain is measured by the patient's self-report, abiding by the clinical definition of pain that states "Pain is whatever the experiencing person says it is, existing whenever he/she says it does" (McCaffery, 1968). Unfortunately, some patients cannot provide a self-report of pain verbally, in writing, or by other means, such as finger span (Merkel, 2002) or blinking their eyes to answer yes or no questions (Pasero & McCaffery, 2002).

This position paper will specifically address three populations of nonverbal patients: Elders with advanced dementia, infants and preverbal toddlers, and intubated and/or unconscious patients. The inability of these populations to communicate pain and discomfort due to cognitive, developmental, or physiologic issues is a major barrier for them being adequately assessed for pain and achieving adequate pain management interventions.

Ethical Tenets:

The ethical principles of beneficence (the duty to benefit another) and nonmaleficence (the duty to do no harm) oblige health care professionals to provide pain management and comfort to all patients, including those challenging individuals who are vulnerable and unable to speak for themselves. Providing quality and comparable care to individuals who cannot report their pain is directed by the principle of justice (the equal or comparative treatment of individuals). Respect for human dignity, the first principle in the "Code of Ethics for Nurses" (ANA, 2001), directs nurses to provide and advocate for humane and appropriate care. Based on the principle of justice, this care is given with compassion and unrestricted by consideration of personal attributes, economic status, or the nature of the health problem.

General Recommendations:

All persons with pain deserve prompt recognition and treatment. Pain should be routinely monitored, assessed, reassessed, and documented clearly to facilitate treatment and communication among health care clinicians (Gordon et al., 2005). In patients who are unable to self-report pain, other measures must be used to detect pain and evaluate interventions. No single objective assessment strategy, such as interpretation of behaviors, pathology or estimates of pain by others, is sufficient by itself. Following are recommended considerations:

1. Utilize the Hierarchy of Pain Assessment Techniques (McCaffery & Pasero, 1999):
 - a. *Self-report.* Attempts should be made to obtain self-report of pain from all patients. A self-report of pain from a patient with limited verbal and cognitive skills may be a simple yes/no or vocalization. When self-report is absent or limited, explain why self-report cannot be used and further investigation and observation are needed.
 - b. *Search for Potential Causes of Pain.* Pathological conditions and common problems or procedures known to cause pain (e.g. surgery, wound care, rehabilitation activities, positioning/turning, blood draws, heel sticks; a history of persistent pain) should trigger an intervention, even in the absence of behavioral indicators. A change in behavior requires careful evaluation of the possibility of additional sources of pain. Generally, one may ASSUME PAIN IS PRESENT (APP) and if there is reason to suspect pain, an analgesic trial can be diagnostic as well as therapeutic (APS, 2003). Pain associated with procedures should be treated prior to initiation of the procedure. Other problems that may be causing discomfort should be ruled out (e.g. infection, constipation) or treated.

- c. *Observe Patient Behaviors.* In the absence of self-report, observation of behavior is a valid approach to pain assessment. Common behaviors that may indicate discomfort in the selected populations have been identified in each section below. Pain behaviors are not always accurate reflections of pain intensity, and in some cases, indicate another source of distress, such as physiologic distress or emotional distress (Pasero & McCaffery, 2005). Potential causes and the context of the behavior must be considered when making treatment decisions. Awareness of individual baseline behaviors and changes that occur with discomfort are very useful in differentiating pain from other causes.
- d. *Surrogate Reporting (family members, parents, caregivers) of Pain and Behavior/Activity Changes.* Credible information can be obtained from a parent or another person who knows the patient well (e.g. spouse, child, caregiver). Parents and caregivers should be encouraged to actively participate in the assessment of pain in their loved one. Familiarity with the patient and knowledge of usual and past behaviors can assist in identifying subtle, less obvious changes in behavior that may be indicators of pain presence.

Discrepancies exist between self-report of pain and external observer judgments of pain severity that occur across varied raters (e.g. physician, nurse, family, aides) and settings (e.g. inpatient, outpatient, acute care, long term care). Thus, judgments by caregivers and clinicians may not be accurate reflections of the severity of pain experienced by nonverbal persons and should be combined with other evidence when possible. A multifaceted approach is recommended that combine direct observation, family/caregiver input, and evaluation of response to treatment.

- e. *Attempt an Analgesic Trial.* An empiric analgesic trial should be initiated if there are pathological conditions or procedures likely to cause pain or if pain behaviors continue following attention to basic needs and comfort measures. Provide an analgesic trial and titration appropriate to the estimated intensity of pain based on the patient's pathology and analgesic history. For mild to moderate pain, a nonopioid analgesic may be given initially (e.g. acetaminophen every 4 hours for 24 hours). If behaviors improve, assume pain was the cause and continue the analgesic and add appropriate nonpharmacologic interventions. If behaviors continue, consider giving a single low dose, short-acting opioid (e.g. hydrocodone, oxycodone, or morphine) and observe effect. If there is no change in behavior, titrate dose upward by 25% to 50% and observe effect. Continue to titrate upward until a therapeutic effect is seen, bothersome side effects occur, or no benefit is determined. It may be appropriate to start the analgesic trial with an opioid for conditions in which moderate to severe pain is expected. Explore other potential causes if behaviors continue after a reasonable analgesic trial. The analgesic titration example is conservative and although strategies for safe titration should be followed, more aggressive approaches may be needed (See Gordon et al., 2004). No research confirms that weight (except in children) should be used to determine starting dose (Burns et al., 1989; Macintyre & Jarvis, 1995).

2. Establish a Procedure for Pain Assessment.

A procedure for evaluating pain presence and response to treatment should be instituted in each health care setting. The hierarchy of assessment techniques, discussed above, is recommended, and the following can be used as a template for the initial assessment and treatment procedure (Pasero & McCaffery, 2005).

- a. Attempt first to elicit a self-report from patient and explain why self-report cannot be used.
- b. Identify pathological conditions or procedures that may cause pain.
- c. List patient behaviors that may indicate pain. Behavioral assessment scales may be used.
- d. Identify behaviors that caregivers and others knowledgeable about the patient think may indicate pain.
- e. Attempt an analgesic trial.

3. Utilize behavioral pain assessment tools, as appropriate.

Use of a behavioral pain assessment tool may assist in recognition of pain in these challenging populations. It is incumbent on health care providers to consider the strength of psychometric evaluation data (e.g. reliability and validity of the tool), the clinical feasibility of instruments (e.g. training required, time to complete), and the support for use with the population of interest in the specific setting (e.g. acute care, long term care [LTC], home care) when selecting a specific tool. Use of reliable and valid tools helps ensure that clinicians are using appropriate criteria in their pain assessments. Standardized tools promote consistency among care providers and care settings and facilitate communication and evaluation of pain management treatment decisions. However, the appropriateness of a scale must be assessed patient by patient and no one scale should be an institutional mandate for all patients in a certain group (Pasero & McCaffery, 2005).

When a behavioral tool is scored, that score is not the same as a pain intensity rating nor can the scores be compared to standard pain intensity ratings or categories of pain severity. Behavioral assessment tools may be helpful to identify the presence of pain and can be used to evaluate attempts to relieve pain (Pasero & McCaffery, 2005). When selecting a behavioral pain assessment tool, be sure the patient is able to respond in all categories of behavior. Keys to the use of behavioral pain scales are to focus on the individual's behavioral presentation and observe for changes in those behaviors with effective treatment. Remember that sleep and sedation do not equate with the absence of pain or with pain relief.

4. Minimize Emphasis on Physiologic Indicators.

Physiologic indicators (e.g. changes in heart rate, blood pressure, respiratory rate) are not sensitive for discriminating pain from other sources of distress. Although often used to document pain presence, little research supports the use of vital sign changes for identifying pain. Absence of increased vital signs does not indicate absence of pain (McCaffery & Pasero, 1999).

5. Reassess and Document. Following intervention and regularly over time, the patient should be reassessed with methods of pain assessment and specific behavioral indicators that have been identified as significant and appropriate for the individual patient. Assessment approaches and pain indicators should be documented in a readily visible and consistent manner that is accessible to all health care providers involved in the assessment and management of pain (Gordon et al., 2005; Miaskowski et al., 2005).

Persons with Advanced Dementia

Guiding principles for the assessment of pain

Recommendations for pain assessment in nonverbal older adults with dementia unable to self-report that are unique from the general recommendations include the following:

1. *Self-report.* The ravages of dementia seriously impact the ability of those with advanced stages of disease to communicate pain. Damage to the central nervous system (CNS) affects memory, language, and higher order cognitive processing necessary to communicate the experience. Yet despite changes in CNS functioning, persons with dementia still experience pain sensation to a degree similar to the cognitively intact older adult (Schuler et al., 2004). However, dementing illnesses do impact the interpretation of the pain stimulus and the affective response to that sensation (Scherder et al., 2005). Although self-report of pain is often possible in those with mild to moderate cognitive impairment, as dementia progresses, the ability to self-report decreases and eventually self-report is no longer possible.

2. *Searches for Potential Causes of Pain/Discomfort.* Consider chronic pain etiologies common in older persons (e.g. history of arthritis, low back pain, neuropathies). Musculoskeletal and neurological disorders are the most common causes of pain and should be given priority in the assessment process. A recent fall or other acute pain-related problem (e.g. urinary tract infection, pneumonia, skin tear) could be the cause of pain.

3. *Observation of Patient Behaviors.* Observe for behaviors recognized as indicators of pain in this population. Facial expressions, verbalizations/vocalizations, body movements, changes in interpersonal interactions, changes in activity patterns or routines, and mental status changes have been identified as categories of potential pain indicators in older persons with dementia (AGS, 2002). A list of indicators included in these categories as well as an algorithm for evaluating pain in persons unable to self-report is available (AGS, 2002). Some behaviors are common and typically considered pain-related (e.g. facial grimacing, moaning, groaning, rubbing a body part), but others are less obvious (e.g. agitation, restlessness, irritability, confusion, combativeness, particularly with care activities or treatments, or changes in appetite or usual activities) and require follow-up evaluation. Typical pain behaviors are often not present and more subtle indicators may represent pain. Use the American Geriatric Society's indicators of pain (AGS, 2002) or a nonverbal pain assessment tool that is appropriate, valid, and reliable for use with this population. Behavioral observation should occur during activity whenever possible, as pain may be minimal or absent at rest.

Use of Behavioral Pain Assessment Tools

Two critiques of existing nonverbal pain assessment tools indicate that, although there are tools with potential, there is no tool that has strong reliability and validity that can be recommended for broad adoption in clinical practice for persons with advanced dementia (Herr et al., in press; Stolee et al., 2005). Existing tools have limited evaluation that is often narrow in the samples used and/or the setting in which evaluation was conducted. Behavioral tools with few indicators may be more clinically feasible but may not detect pain in patients that present with less obvious behaviors. Longer and more comprehensive checklists may be more sensitive but also identify patients for which pain may not be present. Given the current state of high under-recognition of pain in this population, increased sensitivity may be preferable but will require evaluation to validate pain as the cause of the suspect behaviors.

A comprehensive review of currently published tools for assessing pain in nonverbal persons with dementia is available at the following website: www.cityofhope/prc/elderly.asp and in Herr, Bjoro and Decker (in press). Tools are in varying stages of development and validation; however, those

with the strongest conceptual and psychometric support at this time, as well as clinical utility, include:

- ADD: The Assessment of Discomfort in Dementia Protocol, (Kovach et al., 1999; 2001; 2002) (Tested in: long-term care setting; acute/chronic pain)
- CNPI: Checklist of Nonverbal Pain Indicators, (Feldt, 2000a, 2000b; Feldt et al., 1998; Jones et al., 2005) (Tested in: acute care setting, long-term care setting; acute/chronic pain)
- Doloplus 2: The Doloplus 2, (Lebebre-Chapiro, 2001; <http://www.doloplus.com>) (Tested in: long-term care setting, geriatric centers, palliative care center; chronic pain)
- NOPPAIN: Nursing Assistant-Administered Instrument to Assess Pain in Demented Individuals, (Snow et al., 2003) (Tested in: long-term care; acute and chronic pain)
- PACSLAC: The Pain Assessment Scale for Seniors with Severe Dementia, (Fuchs-Lacelle, et al., 2004) (Tested in: long-term care setting; chronic pain)
- PAINAD: The Pain Assessment in Advanced Dementia Scale, (Warden et al., 2003; Lane et al., 2003) (Tested in: long-term care setting; chronic pain; preliminary reports of testing in acute pain not yet published)

Clinicians are encouraged to review selected tools for appropriateness to the patient's care setting and obtain data to support their use through Quality Improvement projects.

4. *Surrogate Reporting of Pain (e.g. family, caregiver).* In the LTC setting, the certified nursing assistant (CNA) is a key health care provider that has been shown to be effective in recognizing the presence of pain (Fisher et al., 2002; Mentis et al., 2004). Education on screening for pain should be a component of all CNA training. Family members are likely to be the caregiver with the most familiarity with typical pain behaviors or changes in usual activities that might suggest pain presence in the acute care setting and in other settings where the health care providers do not have a history with the patient (Cohen-Mansfield, 2002; Shega et al., 2004).

5. *Attempt an Analgesic Trial.* Estimate the intensity of pain based on information obtained from prior assessment steps and select an appropriate analgesic. For example, when mild to moderate pain is suspected, acetaminophen 500-1000 mg every 6 hours may be appropriate initially with titration to stronger analgesics if there is no change in behaviors and pain continues to be suspect. Low-dose opioids have been effective in validating agitation as a pain indicator (Manfredi et al., 2003). Opioid dosing in older adults warrants an initial dose reduction of 25-50%. Using an analgesic trial to validate presence of pain prior to increasing or adding psychotropic medications has several advantages. Compared with psychotropic intervention, response will be seen more quickly with an analgesic intervention, the adverse reactions to analgesics are usually less serious, and pain will not be obscured by the sedative properties of psychotherapeutic agents. With this approach, pain is more likely to be detected and treated. Consider psychiatric approaches, such as adding or changing doses of new psychiatric pharmacologic approaches (e.g. antipsychotics, sedatives), if behaviors do not improve with an analgesic trial.

Infants and Preverbal Toddlers

Guiding principles for the assessment of pain

Recommendations for pain assessment in infants/nonverbal children unable to self-report that are unique from the general recommendations include the following:

1. *Self-report:* Infants, toddlers, and developmentally preverbal children lack the cognitive skills necessary to report and describe pain. As children develop verbal and cognitive skills they are able to report the experience and intensity of pain. The ability to indicate the presence of pain emerges at about two years of age. Developmentally appropriate children as young as three years of age may be able to quantify pain using simple validated pain scales (Spagrud et al., 2003. Fanurik et al., 1998).

2. *Search for Potential Causes of Pain/Discomfort:* Infections, injuries, diagnostic tests, surgical procedures, and disease progression are possible causes for pain in infants and young children and should be treated with the presumption that pain is present. Developmentally nonverbal children have a higher burden of pain from frequent medical/surgical procedures and illness and suspicion of pain should be high. (Stevens et al., 2003).

3. *Observation of Patient Behaviors.* Infants and children react to pain by exhibiting specific behaviors. The primary behavioral categories used to help identify pain in this population include facial expression, body activity/motor movement, and crying/verbalization. Body posture, changes in muscle tone, and response to the environment are also indicators of pain. Facial expressions of an infant experiencing acute pain include eyebrows lowered and drawn together to form a vertical furrow, a bulge between the brows with the eyes tightly closed, cheeks raised with a furrow between the nose and upper lip, and the mouth open and stretched in the shape of square (Grunau & Craig, 1990). In addition, high pitched, tense, and harsh cries have been indicated as a behavioral measure of infant pain (Fuller & Conner, 1995). However, infant behaviors such as crying and facial express that accompany crying are not independent indicators of acute pain (Fuller, 2001).

The primary behavioral signs of pain are often more apparent and consistent for procedural pain and postoperative pain than for chronic pain. As a child gains control over body movement there will be greater differences in observed behavioral responses to pain. Sleeping and withdrawn behavior may be the child's attempts to control pain by limiting activity and interactions. There may be a dampening of the primary pain behaviors in children who experience prolonged pain or chronic pain. Behaviors seen in children with chronic cancer pain include posturing, wariness of being moved, and psychomotor inertia which has been described as withdrawal, lack of expression, and lack of interest in surroundings (Gauvin-Piquard et al 1999). Distress behaviors, such as irritability, agitation, and restlessness, may or may not be related to pain and, in many cases, may indicate physiologic distress, such as respiratory compromise, or drug reactions. Therefore, consider the context of the behaviors, the medical history, and caregiver opinions when using behavioral pain assessment tools and making treatment decisions.

Physiologic indicators, such as heart rate, respiratory rate, and oxygen saturation, have been reported as providing information about the neonatal response to noxious stimuli and are associated with acute pain (Stevens, Johnston, Petyshen & Taddio, 1996). Physiologic indicators, however, are also affected by disease, medications, and changes in physiologic status and, therefore, are not good predictors of pain or the absence of pain (Foster, et al 2003).

Use of Behavioral Pain Assessment Tools

While no single behavioral scale has been shown to be superior to others, clinicians should select a scale that is appropriate to the patient and types of pain on which it has been tested. Behavioral pain tools should be used for initial and ongoing assessments.

- CHEOPS: Children's Pain Scale (McGrath, et al, 1985) (Tested in: 1-5 Years of age; Post Anesthesia Care Unit, surgical pain)
- CHIPPS: (Buttner & Finke, 2000) (Tested in: Birth to 5 years of age: clinic and acute care setting; surgical pain)
- COMFORT Behavior Scale (van Dijk et al., 2005) (Tested in: neonate to 3 years of age; intensive care setting, surgical pain. Revised scale of COMFORT (Ambuel et al., 1992; Canenvale, & Razack, 2002) measures other constructs than pain. (Tested in newborn to 9 years of age, intensive care setting, mechanically ventilated)
- CRIES: (Krechel & Bildner, 1995) (Tested in: Neonates; Neonatal and pediatric intensive care setting, procedural and surgical pain)

- DSVNI: Distress Scale for Ventilated Newborn Infants (Sparshott 1996) (Tested in ventilated newborns, intensive care setting; procedural pain)
- FLACC: Faces, Legs, Activity, Cry, Consolability Observational Tool (Merkel et al, 1997; Manworren & Hynan, 2003; Willis et al., 2003; (Tested in: 2 months to 7 years of age; Post Anesthesia Care, intensive care, acute care settings, surgical pain and acute pain)
- DEGR Scale: Douleur Enfant Gustave Roussy (Gauvin-Piguard, 1999) (Tested in: 2-6 years; acute care, cancer pain)
- PIPP: Premature Infant Pain Profile (Stevens, 1996) (Tested in: premature and term neonates; Neonatal settings, procedural pain)
- RIPS: Riley Infant Pain Scale (Schade et al, 1996) (Tested in: newborn to 3 years of age; acute care setting; surgical pain)
- UWCH (University of Wisconsin Children's Hospital) Pain Scale for Preverbal and Nonverbal Children (Soetenga et al, 1999) (Tested in: Less than 3 years old; acute care setting, surgical and procedural pain)

4. *Surrogate Reporting of Pain.* Include evaluation of the response of the infant, toddler, and developmentally nonverbal child to parents and the environment in the assessment of pain. Responsiveness to interventions by a trusted caregiver to console the child, such as rocking, touch, and verbal reassurance, must be considered when observing distressed behaviors. Parents usually know their child's typical behavioral response to pain and can identify behaviors unique to the child that can be included in the assessment of pain. However, the nursing staff may be most familiar with the infant or young child's pain behavior if the child has not been home since birth.

Explain behavioral scales to parents and encourage them to actively participate in identifying pain and evaluating their child's response to interventions (NANN position statement, 1999).

5. *Analgesic Trial.* Initiate an analgesic trial with a nonopioid or low-dose opioid if pain is suspected and comfort measures, such as parental presence, security items, sucking, and distraction, are not effective in easing behaviors that may suggest pain. Base initial opioid dose on weight and titrate as appropriate. Explore other potential causes of distress if behaviors continue after a reasonable analgesic trial.

Intubated and/or unconscious Persons

Guiding principles for the assessment of pain

Recommendations for pain assessment in intubated and/or unconscious persons unable to self-report that are unique from the general recommendations include the following:

1. *Self-report.* Self-report of pain should be attempted; however, obtaining a report of pain from a critically ill patient may be hampered by delirium, cognitive and communication limitations, level of consciousness, presence of an endotracheal tube, sedatives, and neuromuscular blocking agents. Due to delirium that can wax and wane and impact ability to self-report, serial assessment for the ability to self-report should be conducted.

2. *Potential Causes of Pain/Discomfort.* Sources of pain in critically ill patients include the existing medical condition, traumatic injuries, surgical/medical procedures, invasive instrumentation, blood draws, and other routine care such as suctioning, turning, positioning, drain and catheter removal, and wound care (Puntillo et al., 2001, 2004; Simons et al., 2003; Stanik-Hutt et al., 2001, Jacob & Puntillo, 1999). Verbal adult patients describe a constant baseline aching pain with intermittent procedure-related pain descriptors such as sharp, stinging, stabbing, shooting, and awful pain thus it should be assumed that those unable to report pain also experience these sensations (Puntillo et al 2001). In addition, immobility, hidden infection, and early decubiti can cause pain and discomfort.

3. *Observation of Patient Behavior.* Facial tension and expressions such as grimacing, frowning, and wincing are often seen in critically ill patients experiencing pain. Physical movement, immobility, and increased muscle tone may indicate the presence of pain. Tearing and diaphoresis in the sedated paralyzed and ventilated patient represents autonomic responses to discomfort (Hamil-Ruth & Marohn, 1999). Behavioral pain scales are not appropriate for pharmacologically paralyzed infants, children, adults, or those who are flaccid and cannot respond behaviorally to pain. Assume pain is present and administer analgesics appropriately to patients who are given muscle relaxants and/or deep sedation and experience conditions and procedures thought to be painful. Patients may exhibit distress behaviors as a result of the fear and anxiety associated with being in the ICU. An analgesic trial (see #5 below) may be helpful in distinguishing distress behaviors from pain behaviors.

Relying on changes in vital signs as a primary indicator of pain can be misleading because these may also be attributed to underlying physiologic conditions, homeostatic changes, and medications. There is limited evidence that supports the use of vital signs as a single indicator of pain; however, both physiologic and behavioral responses often increase temporarily with a sudden onset of pain (Foster et al, 2003). Changes in physiologic measures should be considered a cue to begin further assessment for pain or other stressors (Foster, 2001). Absence of increased vital signs does not indicate absence of pain (McCaffery & Pasero, 1999).

Use of Behavioral Pain Assessment Tools. While no single behavioral scale has been shown to be superior for use with this population, tools tested in other settings may be useful if appropriate to the population and pain problem. Tools should be tested to assure they are reliable and valid if used with a population in which they have not been studied.

Pediatrics

- FLACC: Faces, Legs, Activity, Cry, Consolability Observational Tool (Manworren & Hynan, 1995; Merkel et al, 1997; Willis et al., 2003) (Tested in: 2 months to 7 years of age; Post Anesthesia Care, intensive care, acute care settings, surgical pain and acute pain)
- DSVNI: Distress Scale for Ventilated Newborn Infant (Sparshott, 1966) (Tested in ventilated newborns; intensive care setting; procedural pain)
- COMFORT Behavior Scale (van Dijk et al., 2005) (Tested in: neonate to 3 years of age; intensive care setting, surgical pain. Revised scale of COMFORT (Ambuel et al., 1992; Canenvale, & Razack, 2002) Measures other constructs than pain. (Tested in: newborn to 9 years of age; intensive care setting, mechanically ventilated)

Adults

- BPS: Behavioral Pain Scale (Payen, 2001) (Tested in: adults; intensive care; procedural pain age)
- CPOT: Critical-Care Pain Observation Tool (Gelinas et al., in review) (Tested in: adults; intensive care setting; nociceptive procedures)

4. *Surrogate Reporting of Pain.* Parents of children, caregivers, family members and surrogates can help identify specific pain indicators for critically ill individuals. A family member's report of their impression of a patient's pain and response to an intervention should be included as one aspect of a pain assessment in the critically ill patient.

5. *Analgesic Trial.* Initiate an analgesic trial if pain is suspected. . The priority of the analgesic trial is to verify presence of pain. Ongoing treatment should consider the unique issues of this population. The ongoing use of analgesics, sedatives, and comfort measures can provide pain relief and reduce the effect of the stress response. Paralyzing agents and sedatives are not substitutes for analgesics. This population is often being weaned from opioids to support a successful extubation; however suspected pain should be treated. Less sedating agents and

approaches should be considered as appropriate, such as NSAIDS, PCA, Epidural analgesia. In patients with head injury, opioids should be used as appropriate for pain but weighed against the risk of sedation. Short-acting opioids such as fentanyl may allow for appropriate titration yet allow quick retreat if needed

Summary: Individuals who are unable to communicate their discomfort are at greater risk for inadequate analgesia. This position paper describes the severity of this issue, defines populations at risk and offers strategies, tools, and resources for appropriate pain assessment. Nurses have a moral, ethical, and professional obligation to advocate for all individuals in their care. Just like all other patients, these special populations require consistent, ongoing assessment, appropriate treatment, and evaluation of interventions to insure the best possible pain relief. Clinicians are encouraged to monitor current research regarding new developments in strategies and tools for assessing pain in these populations.

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