

ADULTS

The most accurate and reliable evidence of the presence and intensity of pain is the patient’s self-report. Even patients with mild to moderate cognitive impairment may be able to use pain intensity scales (e.g., 0-10, mild-moderate-severe). For patients unable to report pain, screen for the presence of pain by observing behaviors and watching for changes in function (e.g., changes in gait, withdrawn or agitated behavior, moaning, groaning, and crying). UW Health recommends the following instrument as an option to assess and document pain in an adult with cognitive impairment.

Checklist of Nonverbal Pain Indicators (CNPI)

	With Movement	Rest
1. Vocal complaints: Non-verbal (Expression of pain, not in words, moans, groans, grunts, cries, gasps, sighs)		
2. Facial Grimaces/Winces (Furrowed brow, narrowed eyes, tightened lips, jaw drop, clenched teeth, distorted expressions)		
3. Bracing (Clutching or holding onto side rails, bed, tray table, or affected areas during movement)		
4. Restlessness (Constant or intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still)		
5. Rubbing (Massaging the affected area)		
6. Vocal complaints: Verbal (Words expressing discomfort or pain, “ouch”, “that hurts”, cursing during movement, or exclamations of protest: “stop”, “that’s enough”)		
Subtotal Scores		
Total Score		

The CNPI is designed to measure pain behaviors in cognitively impaired elders. The tool includes six pain behavioral items commonly observed in older adults including nonverbal vocalizations, facial grimacing or wincing, bracing, rubbing, restlessness, vocal complaints. Each item is scored on a dichotomous scale (1 = present, 0 = not present, both at rest and on movement, for a possible range of scores from 0 to 6 points for each situation and a total of 12 points. It is important to note that a CNPI score is not equivalent to a pain intensity rating. No interpretation of total score is provided, but changes in the score over time may be helpful to evaluate efficacy of interventions.

Like many aspects of pain management an individualized approach should be utilized. Involve the family if possible to identify specific behaviors in their family member that may indicate pain. Observe and document behaviors and response to analgesics and comfort measures. An in-depth critique of the existing nonverbal pain assessment tools as well as copies of tools (when available) or contact information for accessing is posted at the City of Hope website www.cityofhope.org/prc/elderly.asp [listed under Elderly section, Guidelines and pathways, item # 5].

Pain Fast Facts: Pain Fast Fact: Assessing Pain in the Nonverbal or Cognitively Impaired
continued

CHILDREN

Use the *UW Children’s Hospital Pain Scale for Preverbal and Nonverbal Children* developed and tested on preverbal children (less than 3 years old) and cognitively impaired children to assess pain.

This instrument is for pediatric patients and is NOT appropriate for adults.

Pain Scale for Preverbal and Nonverbal Children

	0	1	2	3	4	5
Vocal/Cry	No Cry	Occasional whimpers		Moaning, gentle cry, or whimpering		Consistent cry that increases in volume and duration
Facial	Smiling, calm, relaxed	Neutral expression, frowning, occasional grimace		Occasional tense expression, slightly negative expression (e.g. grimace), brow bulge, shallow nasolabial furrow		Marked distress. Brow bulge, eyes squeezed shut, open mouth, taut tongue, deepening of naso-labial furrow
Behavioral	Neutral, moves easily, interacts with people or environment, strong rhythmic suck on pacifier	Easy to console with holding, position change, or sucking; winces when touched/moved		Consoles with moderate difficulty; sucks for very short periods followed by crying; cries out when moved/touched		Inconsolable; absent or disorganized sucking; high pitched cry or scream when touched or moved
Body movement/Posture	Normal motor activity, baseline muscle tone	Fidgeting; mild hypertonicity above baseline		Moderate agitation or moderate immobility; intermittent flexion; moderate hypertonicity above baseline		Thrashing, flailing, incessant agitation or strong voluntary immobility; pronounced flexion; strong hypertonicity above baseline
Sleep	Sleeping quietly with easy respirations; normal sleep/rest periods	Restless while asleep		Sleep periods shorter than normal, awakes easily, sleeps intermittently		Unable to sleep or sleeping for prolonged periods of time interrupted by jerky movements
Overall rating (circle):	0	1	2	3	4	5

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References

- Soetenga D, Frank J, Pellino TA. Assessment of the validity and reliability of the University of Wisconsin Children’s Hospital Pain scale for Preverbal and Nonverbal Children. *Pediatric Nursing* 1999;25(6):670-676.
- Feldt, KS. Checklist of Nonverbal Pain Indicators. *Pain Management Nursing* 2000; 1(1):13-21.
- Herr K et al. Tools for assessment of pain in nonverbal older adults with dementia: a state-of-the-science review. *Journal of Pain and Symptom Management* 2006;31(2):170-192.



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