Table 5: Tailoring Pain Management to Older Adults With Cognitive Impairment$^{1,2,9}$

- Creativity and collaboration with those familiar with the patient is necessary.
- Assess and treat depression, a common cause of cognitive impairment in older adults.
- Use pain assessment measures specifically designed for people who are cognitively impaired.
- Pain faces and numerical scales may be easier and more reliable than verbal methods, but self-report, with short questions framed in the present tense, remains a reliable method unless patient is severely cognitively impaired.
- Obtain baseline measures, including pain and mental status assessments, before initiating treatment; repeat measures during and after regimen.
- Observe for nonverbal signs and behavior changes, such as increased confusion, altered gait, grimace or teeth grinding, loss of appetite, restlessness, disturbed sleep, muscle tension, splintering, guarded mobility, massaging the painful site, agitation, diaphoresis, unusual vocalizations, yelling, pulling at bedding, social withdrawal, reluctance to engage in activities of daily living, pacing.
- Ask people who know the patient day-to-day about the patient’s unique nonverbal and behavioral indicators of pain, paying particular attention to ethnic and cultural nuance.
- Combining pharmacologic with nonpharmacologic methods is as effective with people who have cognitive impairment as it is with those not cognitively impaired.
- Patients with cognitive impairment experience the same adverse drug reactions and consequences of pain as older adults who are not cognitively impaired; therefore: a) monitor liver function closely for patients on acetaminophen; b) monitor kidney function and gastrointestinal distress closely for patients on NSAIDs; and c) monitor respiratory function and bowel habits closely for patients on opioids.
- Patients experience withdrawal, reluctance to engage in activities of daily living, pacing.
- Often are indicators of pain, but do not relieve physical pain.
- ADRs precipitating factors; c) using nonpharmacologic methods to provide comfort and pain relief; d) medicating with ordered nonopioid analgesia if comfort measures fail; e) titrating opioids on order in small steps; and f) regularly observing for changes in behavioral indicators of pain.$^{1,9}$

Medicating with psychotropic medications —used excessively in the past with older adults who are cognitively impaired—may relieve the behavioral symptoms that often are indicators of pain, but they do not relieve physical pain.$^9$ ADRs and interactions of psychotropics with analgesics exacerbate confusion, dizziness, gait disturbances and falls, and should only be used as a last resort (see Table 5 for additional adaptations that may be necessary).

**What’s Next**

Evidence about the efficacy and ADRs associated with prescribed medications is stronger than the evidence about nonpharmacologic methods. But complementary and alternative methods (CAM) are increasingly being used by older adults, often in conjunction with pharmaceuticals. The next part of this series highlights promises and pitfalls of CAM with an emphasis on judicious and informed integration of both pharmacologic and CAM strategies to manage older adults’ pain.$^9$

**References**


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