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Interdisziplinäre Leitlinie des Arbeitskreises Schmerz und Alter der Deutschen Schmerzgesellschaft e. V. und des Deutschen Zentrums für Neurodegenerative Erkrankungen (DZNE, Witten) und der beteiligten Berufsverbände, Fachgesellschaften und Organisationen[1]

LEITLINIENSYNOPSE zur S3-LEITLINIE: „Schmerzassessment bei älteren Menschen in der vollstationären Altenhilfe“

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Deutsche Gesellschaft für Allgemeinmedizin und Familienmedizin (DEGAM)
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Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde e.V. (DGPPN)
Deutsche Interdisziplinäre Vereinigung für Schmerztherapie (DIVS), [assoziiert]
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Deutsche Gesellschaft für Pflegewissenschaft e. V. (DGP)
Deutsche Gesellschaft für Psychologie e. V., DGPs
Deutsche Gesellschaft für Schmerztherapie e. V. (DGS)
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Deutsche SCHMERZLIGA e. V.
Deutscher Berufsverband für Altenpflege e. V. (DBVA)
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Deutsche Gesellschaft für AlterszahnMedizin (DGAZ)
Deutscher Pflegerat e. V.
Netzwerk „Musiktherapie mit alten Menschen“
Deutsche Vereinigung für Sozialarbeit im Gesundheitswesen(DVSG)

Die operative Arbeit an dieser Leitlinie erfolgte in drei Arbeitsgruppen.

AG Screening von Schmerz bei älteren Menschen in der vollstationären Altenhilfe:

- Gnass Irmela
- Schuler Matthias (AG Leitung)
- Wilms Florian
- Laekeman Maria-Anna
- Sirsch Erika

AG Assessment von Schmerz bei älteren Menschen in der vollstationären Altenhilfe

- Leonhard Corinna (AG Leitung)
- Laekeman Maria-Anna
- Higman Patience
- Wilms Florian
- Sirsch Erika

AG Verlaufserfassung bei Schmerz bei älteren Menschen in der vollstationären Altenhilfe

- Fischer Thomas (AG Leitung)
- Drebenstedt Corinna
- Berkemer Esther
- Wilms Florian
- Sirsch Erika

Inhalt

1 Hintergrund

Ein adäquates Schmerzassessment für ältere Menschen in der vollstationären Altenhilfe ist ein erster und wichtiger Schritt zur Verbesserung der Schmerztherapie bei Senioren. Das trifft gleichermaßen sowohl bei aussagefähigen Personen, als auch bei in ihrer Kommunikation oder Kognition eingeschränkten Menschen zu.
Die Mitglieder des Arbeitskreises Schmerz und Alter der Deutschen Schmerzgesellschaft sahen die Notwendigkeit, eine interdisziplinäre Leitlinie „Schmerzassessment bei älteren Menschen in der vollstationären Altenhilfe“ zu entwickeln.
Diese Leitlinie wird federführend durch die Deutschen Schmerzgesellschaft und das Deutsche Zentrum für Neurodegenerative Erkrankungen (DZNE), Witten unter Beteiligung von 38 Fachgesellschaften und Interessengruppen entwickelt.
Das Leilinienvorhaben wurde am 09.06.2011 als S3-Leitlinie bei der Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) angemeldet und unter der Nummer 145-001 registriert (vgl. AWMF 2011).
Die vorliegende Synopse beinhaltet die Recherche nach national und international verfügbaren Leitlinien, die sich als Quell-Leitlinien eignen. Sie weist deren methodische und inhaltliche Bewertungen aus und fasst die relevanten Ergebnisse, die bei der Erstellung der S3-Leitlinie Berücksichtigung finden sollten, zusammen.

2 Ziel der Leitliniensynopse

Diese systematische Recherche ist der erste notwendige Schritt zur Identifikation der bestverfügbaren Evidenz (Deutsches Cochrane – Zentrum et al. 2013: S.7)
In dieser Synopse werden zu den vorab konsentierten klinisch relevanten Fragen die ersten Antworten aus den Quell-Leitlinien generiert. Diese bilden die Grundlage für die nachfolgenden evidenzbasierten Empfehlungen der Leitlinie „Schmerzassessment bei älteren Menschen in der vollstationären Altenhilfe“. Die Synopse liefert damit einen gebündelten Überblick über national und international bestehende Wissensbestände zum Schmerzassessment bei älteren Menschen. Desweiteren verdeutlicht die systematische Übersicht, welche Evidenz- und Informationslücken bestehen und für welche Bereiche ggf. weiter recherchiert werden muss.

3 Methodik

In diesem Kapitel wird das methodische Vorgehen bei der Recherche und der Auswertung der Publikationen beschrieben. Die Suche zur Synopse wird im Zeitraum 10/2011 – 11/2011 durchgeführt.

3.1 Fragestellung

Als erster Schritt wird nach existierenden nationalen und internationalen Leitlinien zum Thema: „Schmerzassessment bei älteren Menschen in der vollstationären Altenhilfe“ recherchiert.
Diese Recherche wird zunächst in 4 Oberbegriffe unterteilt: Schmerz, ältere Menschen, Leitlinien und vollstationären Altenhilfe (vgl. Tabelle 1).

3.2 Datenbanken

Die Auswahl der anvisierten Datenbanken orientiert sich an den Ausführungen von Leitlinienentwicklergruppen (vgl. Deurenberg et al. 2007) und nach Absprache mit der Steuergruppe und der Leitlinienkoordination. Die Recherche erfolgt in den Datenbanken:

- CINAHL [EBSCO]
- The Cochrane Library
- Embase [DIMDI]
- MEDLINE [PubMed]
- Virtuelle Fachbibliothek für Medizin und Gesundheit [MEDPILOT]
- PsycINFO [OVID]

Desweiteren erfolgt eine Suche auf den Internetseiten von Leitlinien-Organisationen:

- Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e. V. (AWMF);
- G_I_N: International Guideline Library,
- National Guideline Clearinghouse,
- SIGN: Scottish Intercollegiate Guidelines Network,
- Leitlinien-Informations- und Recherche-Dienst des Ärztlichen Zentrums für Qualität in der Medizin – ÄZQ (Gemeinsames Institut von Bundesärztekammer und Kassenärztlicher Bundesvereinigung),
- NICE (National Institute for Health and Clinical Excellence)

Zusätzlich erfolgt eine Suche auf den Internetseiten von Institutionen und Organisationen, die zu den relevanten Themenbereichen arbeiten, z. B.:

- Fachgesellschaften zum Thema Schmerz aus den USA, Australien, Canada etc.
- Geriatrische Organisationen aus den USA, Australien, Belgien, Canada etc.
- Universitäre Einrichtungen, z. B.: University of IOWA College of Nursing

Es wird eine Handsuche in Datenbeständen der Mitglieder des Arbeitskreises durchgeführt.

3.3 Entwicklung und Aufbau der Suchstrategie

Die Suchwortsystematik orientiert sich an den Empfehlungen zu Suchfiltern bezüglich der Identifizierung von geriatrischer Literatur (Kastner et al. 2006; van de Glind et al. 2011). Weitere Hinweise für geeignete Suchworte liefern bereits vorliegende Leitlinien (BPS & BGS 2007, Herr, Bjoro et al. 2006; verenso 2011). Aus diesen Literaturquellen werden die, für die aktuelle Leitlinienrecherche relevanten, Suchworte übernommen.
So weist diese Originalliste der britischen Leitlinie (BPS & BGS 2007) folgende Begriffe aus: "(…) pain or discomfort or agitation and assessment or scales or measurement or behavioral measures or multidimensional measures of pain or quality of life or depression or anxiety and older people or elderly or aged or dementia or cognitive impairment."
In der Tabelle zur Identifikation von Suchbegriffen werden daraus für den ersten Oberbegriff „pain and assessment or scales or measurement" als Suchworte aufgenommen. Für den Oberbegriff „Ältere Menschen" wird „older persons or elderly or aged" übernommen.
(vgl. Tabelle 1).

Tabelle 1: Identifikation von Suchbegriffen

Oberbegriffe	**Schmerz**	**Ältere Menschen**	**Leitlinie**	**Vollstationäre Altenhilfe**
Englische Übersetzung	pain	elderly	guideline	longterm care
Suchworte	pain assessment pain measurement/methods pain measurement pain scales	geriatric older residents seniors older persons aged geriatric patient	guideline practice guideline draft guideline Health Technology Assessment	community-dwelling nursing homes nursing residential home homes for the aged nursing home residents residential care setting residential care institutions

[Anm.: Die Recherche verläuft überwiegend in englischsprachigen Datenbanken und Internetseiten, daher werden die Suchworte in englischer Sprache abgebildet]

Bei ersten Probesuchen stellt sich die Suche nach Setting „stationäre Altenhilfe" als eine zu starke Eingrenzung dar, viele Leitlinien weisen dieses Setting nicht explizit aus, fokussieren

aber dennoch darauf. Das Setting „stationäre Altenhilfe“ wird daher nicht mehr als ausschließlicher Oberbegriff im Suchaufbau verwendet.
Die Eingabe in die Datenbanken unterscheidet sich je nach Suchoberfläche und erfordert zum Teil einen eigenen Suchaufbau. Exemplarisch wird hier der Suchaufbau für die Datenbank Medline mit der Suchoberfläche PubMed ausgewiesen (vgl. Tabelle 2).

Tabelle 2: Beispiel Suchaufbau: Recherche nach Leitlinien „Schmerzassessment bei älteren Menschen“ in Medline (Suchoberfläche PubMed) [Stand 11.11.2011]

Nr.	Suche	Ergebnis
1	pain [MeSH]	270192
2	pain measurement/methods [MeSH]	8071
3	pain measurement [MeSH]	48892
4	pain assessment [tiab]	2491
5	pain scales [tiab]	519
6	**1 OR 2 OR 3 OR 4 OR 5**	**287488**
7	elderly [MeSH]	2019081
8	geriatric [MeSH]	2019081
9	older [tiab]	212430
10	residents [tiab]	53985
11	seniors [tiab]	3655
12	older persons [tiab]	5809
13	**7 OR 8 OR 9 OR 10 OR 11**	**2160011**
14	guideline [MeSH]	92588
15	practice guideline [tiab]	2123
16	Health Technology Assessment [tiab]	1266
17	draft guideline [tiab]	79
18	**14 OR 15 OR 16 OR 17**	**94911**
19	**6 AND 13 AND 18**	**475**
20	**19 und Einstellung von Limitierungen über Filter: Humans, Practice Guideline, Guideline, English, French, German, Spanish, Dutch, Norwegian, Aged: 65+ years, 80 and over: 80+ years**	**4**

3.4 Inklusions- und Exklusionskriterien

Für die Synopse zur S3-Leitlinie „Schmerzassessment bei älteren Menschen in der vollstationären Altenhilfe“ werden Ein- und Ausschlusskriterien für die Bereiche: Population, Publikationsdatum, Publikationstyp, Sprache und Klassifizierung des Schmerzes definiert.

Einschlusskriterien:

- Population: Ältere Menschen ≥ 65 Jahre / weiblich, männlich,
- Publikationszeitraum: 2000 - 2012
- Publikationstyp: Leitlinien oder „Health Technology Assessments“
- Sprachen: Deutsch, Englisch, Niederländisch, Französisch, Spanisch oder Norwegisch
- Schmerz: akut, chronisch oder persistent

Ausschlusskriterien:

- Population: Menschen < 65 Jahre
- Publikationszeitraum: < 2000
- Publikationstyp: Leitlinien nicht zugänglich / kein Volltextzugang / ohne aktuelle Informationen / Duplikates
- Schmerz: ausschließlich auf spezifische Pathologien bezogen (z. B. Brustkrebs, Diabetes)

3.4 Vorgehen zum Einschluss und weiteren Bearbeitung der Quell-Leitlinien

Eine erste Auswahl an Leitlinien erfolgt mittels der oben aufgeführten Suchstrategie. Ein erstes Screening zum Einschluss erfolgt anhand des Titels der Suchworte („MeSH Terms“).
Ein zweites Screening erfolgt anhand der Sichtung der ggf. vorhandenen Abstracts oder durch Querlesen. Nach den beiden Screening-Durchgängen und Entfernung der Duplikate wurden die Suchergebnisse von zwei unabhängigen Reviewern auf Relevanz geprüft und abgeglichen (M.L. & E.S.), die Ergebnisse sind in dem Flussdiagram im Kapitel 4 dargestellt. Parallel werden dazu zwei voneinander unabhängige methodische Bewertungen der Quell-Leitlinien vorgenommen. Der endgültige Einschluss erfolgt durch Konsentierung in der Steuergruppe.

4 Ergebnisse

In diesem Abschnitt werden die Ergebnisse der Recherche und die Auswahl der Quell-Leitlinien dargelegt.

4.1 Ergebnisse der Leitlinienrecherche

Die Ergebnisse der Recherche werden in Tabellenform abgebildet (vgl. Tabelle 3). Die systematische Recherche lieferte insgesamt 15 eventuell geeignete Quell-Leitlinien.

Tabelle 3: Übersicht: Ergebnisse der Quell-Leitlinien Recherche

Quelle	Letzte Suche	Ergebnis nach Screening der Titel, "addressed MeSH terms" oder Abstracts
Datenbanken & Internetseiten von Leitlinien-Organisationen		
AWMF Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V.	10.11.2011	0
ÄZQ / www.leitlinien.de	10.11.2011	0
CINAHL (Cumulative Index to Nursing and Allied Health))	31.10.2011	0
THE COCHRANE LIBRARY	10.11.2011	0
EMBASE (via DIMDI)	02.11.2011	0
G_I_N: International guideline library	29.10.2011	0
MEDLINE (Suchoberfläche PubMed)	11.11.2011	0
MEDPILOT	08.11.2011	1
National Guideline Clearinghouse	30.10.2011	7
NICE (National Institute for Health and Clinical Excellence	25.10.2011	0
PsycINFO (Suchoberfläche OVID)	18.11.2011	0
SIGN: Scottish Intercollegiate Guidelines Network	29.10.2011	0
Sonstige Quellen		
Geriatric Societies, Pain Societies, etc.	13.11.2011	3
Leitlinien die dem AK „Schmerz und Alter" vorlagen	30.10.2011	3
Hinweis auf „Richtlijn" v. Expertin aus Niederlande	21.11.2011	1
	Insgesamt	**15**

4.2 Ergebnisse der Auswertung

Zunächst wurden durch die beiden Reviewer 15 Leitlinien als mögliche Quell-Leitlinien eingeschlossen. Diese wurden an die Mitglieder der Arbeitsgruppen (AG Screening, AG Assessment & AG Verlaufskontrolle) weitergeleitet. Nach der Überprüfung der Volltexte auf Relevanz und im Hinblick auf die Ein- und Ausschlusskriterien durch die Mitglieder der drei Arbeitsgruppen (Screening, Assessment und Verlaufserfassung) wurden durch Konsensbeschluss letztendlich 12 Leitlinien eingeschlossen.

Zwei Leitlinien wurden während dieser Prozedere ausgeschlossen, da sie das Thema Schmerzassessment ausschließlich zu spezifischen Bereichen abhandelten (neurologic assessment & palliative care). Die beiden britischen Leitlinien wurden zusammen ausgewertet, da sie inhaltliche Übereinstimmung zeigten. Zudem wurden sie durch die gleiche Organisation zum gleichen Zeitpunkt herausgegeben.

Das Flussdiagramm informiert über die verschiedenen Phasen des Review Prozesses.

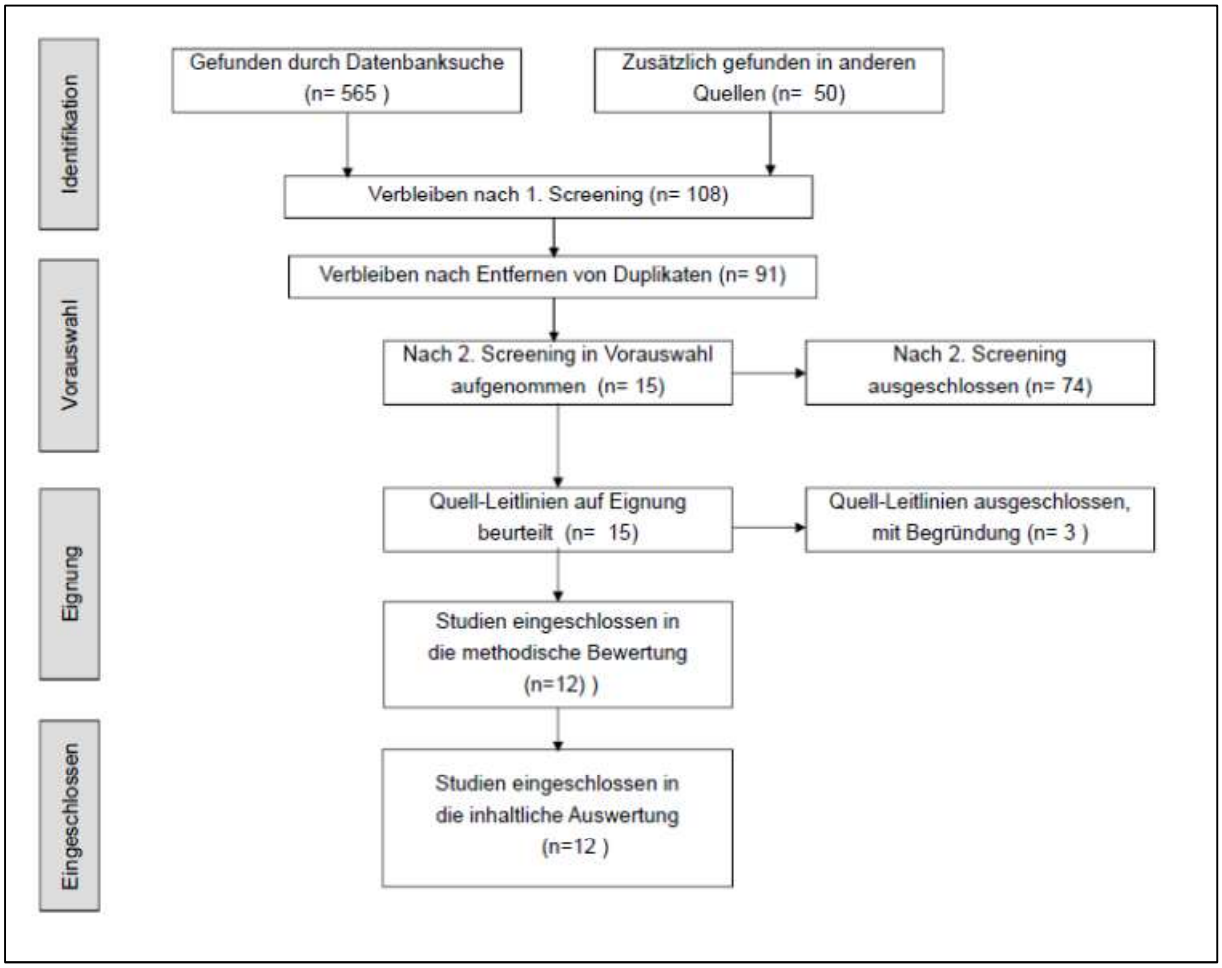

Abbildung 1: Flussdiagramm zur Beschreibung der verschiedenen Phasen der Leitlinienrecherche (modif. nach Moher et al., 2009)

Die nachfolgend abgebildete Tabelle vier bietet eine alphabetische Übersicht der inkludierten Quell-Leitlinien mit Angaben der Quellen.

Tabelle 4: Ergebnisse der Leitlinienrecherche nach 1. und 2. Screening [Stand 21.11.2011]

Quell-Leitlinien	Kürzel	Quelle
AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society. 2002 Jun;50(6 Suppl):S205-224.	AGS_2002	Bei "AK Schmerz & Alter" vorhanden
American Medical Directors Association. Pain management in the Long Term Care Setting. Clinical Practice Guideline. Columbia, MD: AMDA; 2012: & Guideline Summary NGC-7638American Medical Directors Association (AMDA). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 2009.	AMDA_2012	NGC
Australian Pain Society (APS) (2005) Pain in Residential Aged Care Facilities – Management Strategies	APS_2005	Australian Pain Society
British Pain Society and British Geriatrics Society. Guidance on: The assessment of pain in older people. 2007 & Royal College of Physicians, British Geriatrics Society and British Pain Society. The assessment of pain in older people: national guidelines. Concise guidance to good practice series, No 8. London: RCP, 2007.	BPS & BGS_2007 & RCP_2007	British Pan Society & British Geriatric Society & Bei "AK Schmerz & Alter" vorhanden
Hadjistavropoulos T, Fitzgerald TD, Marchildon GP. Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities. Physiother Can. 2010 Spring;62(2):104-113.	Hadjistavropoulos et al_2010	Medpilot
Hadjistavropoulos T, Herr K, Turk DC, Fine PG, Dworkin RH, Helme R, Jackson K, Parmelee PA, Rudy TE, Lynn Beattie B, Chibnall JT, Craig KD, Ferrell B, Ferrell B, Fillingim RB, Gagliese L, Gallagher R, Gibson SJ, Harrison EL, Katz B, Keefe FJ, Lieber SJ, Lussier D, Schmader KE, Tait RC, Weiner DK, Williams J. An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain. 2007 Jan;23(1 Suppl):S1-43.	Hadjistavropoulos et al_2007	Bei "AK Schmerz & Alter" vorhanden
Health Care Association of New Jersey (HCANJ). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2006 Jul 18.	HCANJ_2006	NGC
Herr K, Bjoro K, Steffensmeier J, Rakel B. Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2006 Jul.	Herr et al_2006	NGC
Horgas AL, Yoon SL. Pain management. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. P. 199-222.	Horgas et al_2008	NGC
Mc Lennon M. Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa Gerontological Nursing Interventions Research Center Research Translation and Dissemination Core. 08/2005	Mc Lennon_2005	Iowa University (College of Nursing)
Registered Nurses Association of Ontario (RNAO). Assessment and management of pain. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2002 Nov. & Registered Nurses Association of Ontario (RNAO). Assessment and management of pain: supplement. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007 Feb.	RNAO_2002	NGC
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters).Herkenning en behandeling van chronische pijn bij kwetsbare ouderen. 2011. Deel 1 - samenvatting, aanbevelingen, indicatoren en medicatietabellen. Deel 2 – integrale tekst met onderbouwing van conclusies en aanbevelingen. Deel 3 – bijlage. Handleiding & Patiëntenfolder	Verenso_2011	Hinweis auf „Richtlijn" v. niederländische Expertin

Citation tracking

Es wurde zudem ein „forward citation tracking" durchgeführt. Hier wurde gezielt nach der Zitierung der identifizierten Leitlinien in speziellen Zitationsdatenbanken wie Scopus und Google Scholar gesucht. Das erste Screening der Titel und vorhandener Abstracts ergab 87 Records, nach dem zweiten Screening verblieb noch eine Leitlinie, die bereits als Quell-Leitlinie aufgenommen war.

Das „backwards citation tracking" erbrachte zahlreiche Hinweise auf zitierte Leitlinien, allerdings handelte es sich dabei meistens um bereits inkludierte Leitlinien. Nach dem ersten Screening der Titel und wenn vorhanden Abstracts verblieben drei Leitlinien. Eine, der im Expertenstandard Schmerzmanagement in der Pflege bei akuten Schmerzen- (DNQP 2011) zitierten, Leitlinien wurde ebenfalls angesehen.

Nach weiterer Überprüfung wurden diese vier Leitlinien wieder exkludiert. Sie fokussierten primär auf Akutschmerz und Therapie im Akutsetting, oder das Schmerzassessment bei älteren Menschen wurde als randständiges Thema behandelt. Wurden keine eigenen Empfehlungen ausgewiesen und dazu auf andere Autoren verwiesen, die bereits berücksichtig waren, führte das ebenfalls zum Ausschluss.

Die Aktualisierung der Leitlinienrecherche wurde durch monatliches nachrecherchieren, wenn möglich durch ein Alert-System, gewährleistet. Die letzte Abfrage erfolgte am 04.08.2013. Während dieser Zeit wurde eine weitere eventuell geeignete Leitlinie identifiziert. Deren Überprüfung ergab, dass Schmerzassessment nicht behandelt wird. Die Autoren verweisen dazu explizit auf die britische Leitlinie („the assessment of pain in older people" National Guidelines 2007), die bereits in dieser Synopse eingeschlossen wurde.

4.3 Überprüfung der methodischen Qualität der Leitlinie

Die Überprüfung der methodischen Qualität der Quell-Leitlinien erfolgt nach den Empfehlungen aus dem Deutschen Instrument zur methodischen Leitlinien-Bewertung (DELBI) (vgl. AWMF 2008).
Zwei Mitglieder der Steuergruppe bewerteten unabhängig voneinander die Methode der Quell-Leitlinien. Diese Bewertungen wurden in eine Übersichtstabelle zusammengetragen. Dabei ergaben sich für einzelne Domänen Abweichungen. Die Mitglieder der Steuergruppe definierten dazu ein Konsensverfahren. Für jede Domäne wurde die maximal erreichbare Punktzahl ermittelt. Ergab sich zwischen den Bewertungen eine Abweichung von > 25% der maximalen Punktzahl der jeweiligen Domäne, fand eine erneute Überprüfung statt. Die nachfolgende Tabelle 5 stellt die Endergebnisse der DELBI-Bewertung dar.

Nicht bei allen Quell-Leitlinien war die Domäne acht beurteilbar, zudem weisen die Kriterien der einzelnen Domänen eine hohe Diversität auf. Eine Berechnung des Gesamt Score und ein Ranking waren daher wenig sinnvoll.
Die nachfolgend abgebildete Tabelle dient daher der Übersicht der Bewertung der Quell-Leitlinien.

Tabelle 5: Methodische Bewertung der Leitlinien Übersicht

Quell-Leitlinie	Domäne 1	Domäne 2	Domäne 3	Domäne 4	Domäne 5	Domäne 6	Domäne 7	Domäne 8
AGS_2002	0,50	0,38	0,36	0,38	0,39	0,25	0,31	0,67
AMDA_2012	0,17	0,17	0,26	0,38	0,17	0,08	0,17	0
APS_2005	0,22	0,17	0,05	0,63	0,11	0	0,17	0
BPS & BGS_2007 & RCP_2007	0,44 0,33	0,21 0,50	0,24 0,29	0,54 0,63	0,06 0,06	0 0,08	0,25 0,17	./. ./.
Hadjistavropoulos et al_2010	0,11	0,17	0	0,25	0	0,08	0,06	0
Hadjistavropoulos et al_2007	0,56	0,33	0,24	0,42	0,06	0,17	0,17	./.
HCANJ_2006	0,22	0,08	0	0,38	0,06	0	0,17	./.
Herr et al_2006	0,67	0,08	0,43	0,67	0,06	0	0,17	0
Horgas et al_2008	0,22	0,21	0,24	0,33	0,17	0,08	0,11	0,67
Mc Lennon_2005	0,39	0,29	0,19	0,29	0,11	0,25	0,25	0
RNAO_2002	0,83	0,42	0,52	0,75	0,28	0,17	0,58	0,37
Verenso_2011	0,78	0,71	0,69	0,83	0,56	0,83	0,75	0,47

4.4 Verwendete Evidenzgrade und Empfehlungsstärken in den Quell-Leitlinien als Originalzitate

Bei der Suche nach den Originalzitaten bezüglich Evidenzgraden und Empfehlungsstärken zeigte sich, dass die in den Quell-Leitlinien sehr unterschiedlich ausgewiesen werden. Diese Diversität macht einen Vergleich von Aussagen aus den unterschiedlichen Quell-Leitlinien problematisch. Eine Übersicht der Angaben aus den Quell-Leitlinien wird in diesem Kapitel mit der Ausweisung der jeweils verwendeten Graduierung der Evidenzgrade und Empfehlungsstärken der Quell-Leitlinien (Originalzitate) abgebildet. Es lagen nicht für alle Quell-Leitlinien Angaben zur Graduierung von Evidenz und Empfehlungsstärken vor.

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society
Key to designation to of Quality and Strengths the evidence
“Quality of evidence Level I Evidence from at least one properly randomized, controlled trial Level II Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies, from multiple time-series studies, or from dramatic results in uncontrolled experiments Level III Evidence from respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.”
“Strength of evidence A Good evidence to support the use of a recommendation; clinicians “should do this all the time” B Moderate evidence to support the use of a recommendation; clinicians “should do this most of the time” C Poor evidence either to support or to reject the use of a recommendation; clinicians “may or may not follow the recommendation” D Moderate evidence against the use of a recommendation; clinicians “should not do this” E Good evidence against the use of a recommendation, which is therefore “contraindicated” “

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
“AMDA`s Clinical Practice Committee has chosen to use the following criteria for assigning grade of evidence Quality of Evidence: **High:** At least 1 randomized controlled trial (RCT) or 3 pre/post interventions or other prospective interventions or 3 well-structured, relevant observational studies. **Moderate:** Studies that use well-tested methods to make comparisons in a fair way, but where the results leave room for uncertainty (e.g., because of the size of the study, losses to follow-up, or the method used for selecting groups for comparison). **Low:** Studies in which the results are doubtful because the study design does not guarantee that fair comparisons can be made.

Strength of Recommendation
Strong: Benefits clearly outweigh risks.
Weak: Benefits are balanced with risks.
Insufficient: Evidence is inadequate to make a recommendation.
Criteria for decreasing the grade of a recommendation:
2 Serious (- 1) or very serious (- 2) limitation to study quality
3 Important inconsistency (- 1)
4 Some (- 1) or major (- 2) uncertainty about directness
5 Imprecise or sparse data (- 1)
6 High probability of reporting bias (-1)
Criteria for increasing the grade of a recommendation:
• Strong evidence of association: Significant relative risk greater than 2 (less than 0.5), based on consistent evidence from two or more observational studies, with no plausible confounders (+1)
• Very strong evidence of association: Significant relative risk greater than 5 (less than 0.2), based on direct evidence with no major threats to validity (+2)
• Evidence of a dose-response gradient (+ 1)
• All plausible confounders would have reduced the effect (+ 1)

These criteria are cumulative - e.g., if RCTs have serious limitations and there is uncertainty about the directness of the evidence, the grade of evidence would drop from high to low."

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005). (S. iv)

The recommended strategies are based on the best available research evidence. There is also a great need for further research to improve this evidence base.

BPS & BGS_2007 & RCP
"The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS. & Royal College of Physicians, British Geriatrics Society and British Pain Society. The assessment of pain in older people: national guidelines. Concise guidance to good practice series, No 8. London: RCP, 2007.
Royal College of Physicians (RCP); Appendix 1. Guideline development process / (S. 7):

"There is an urgent clinical need to improve both practice and the evidence base underpinning the assessment of pain on older people. Much of the research in this field to date has been descriptive and/or qualitative. Therefore, it has not, been possible to develop a robust guideline based on graded evidence in the usual manner. However, given the need to improve practice for this most fundamental aspect of care, we have prepared this guidance based on best available evidence and practice [for detail of methodology see Appendix 1] "

"Rigour of development
Evidence gathering Search strategy: Relevant full length articles were identified using electronic searches in Medline, PubMed, OVID Medline, CINAHL, EMBASE, AMED, SciSearch & Cochrane. Evidence-based reviews were identified from OVID, Cochrane, ACP Journal Club, DARE and CCTR. Psychological and social science literature was sought through PsychINFO and ASSIA. Conference papers were searched via IASP, the British Pain Society and the European Pain Society. Relevant publications were included. Inclusion criteria: Papers describing original studies, evidence-based guidelines or systematic reviews Studies including older people (65 and over) with or without cognitive impairment Pain was defined as both acute and persistent, according to the International Association for the Study of Pain (IASP) definitions, but the focus was on persistent pain (www.iasp-pain.org/terms-p.html).
Studies including pain assessment
Papers published after 1990

Exclusion criteria: Paediatric literature (…) Link between evidence The GDG developed recommendations on the basis of the evidence presented by the and recommendations critical appraisal team.”

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities long-term care facilities. (S. 104)
“Recommendations: We encourage the ongoing and regular evidence-based pain assessment of older persons with dementia, using standardized procedures. Without regular and systematic assessment, pain problems will often go undetected in this population. Given the need for systematic pain assessment and intervention for long-term care populations with mobility concerns and muculoskeletal pain problems, we call for increased involvement of physical therapists in long-term care facilities.”

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23 (1): S1-S43. (S. S2)
CONSENSUS DEVELOPMENT METHODOLOGY “The consensus process was initiated by a subgroup of a research team funded by the Institute of Aging, Canadian Institutes of Health Research. On the basis of publication record, grant awards in the field and with the aim of achieving a broad representation of disciplines, the team members invited an interdisciplinary set of 24 international experts to join the effort. Twenty-two of those invited accepted the invitation to participate. Once an initial group was formed, group members were asked to recommend additional individuals who could complement the team. Two additional people were identified who were included in the group consisting of 24. The consensus group represents the disciplines of anaesthesiology, family medicine, geriatric medicine, neurology, nursing, occupational therapy, pain medicine, pharmacy, physiotherapy, psychology, and rheumatology.”

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ). (S. 3)
“The Committee’s development process included a review of government regulations, literature review, expert opinions, and consensus. The Committee strives to develop guidelines that are consistent with these principles: • Relative simplicity • Ease of implementation • Evidence-based criteria • Inclusion of suggested, appropriate forms • Application to various long term care settings • Consistent with statutory and regulatory requirements • Utilization of MDS (RAI) terminology, definitions and data collection”

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core. (S. 6)

Classification of Evidence: individual studies

"Each individual study was classified by study type, external validity and internal validity.
- The type of study was ranked ordinally in categories from I to V as follows:
I Meta-analysis
II Experimental or quasi-experimental study
III Observational study (e.g., a correlational or descriptive study)
IV National guideline recommendation or integrated review
V Expert opinion or multiple case reports
- Within the context of this guideline, external validity refers to generalizability of the studies to the older adult population. Each study was rated on the following scale:
a = the study was conducted in the older adult population or the mean age of study subjects suggests older patients were included.
b = the study was conducted in the general adult population.
- Internal validity of individual studies was evaluated using criteria checklists appropriate for the study type and rated as good, fair or poor. Studies rated poor were excluded from the guideline recommendations. The level of evidence for individual studies is provided in the reference list at the end of the guideline. The type of study (I-V) and external validity (a or b) is indicated after each reference in the list. Only individual studies with good or fair internal validity were included as supporting evidence for recommendations"

Strength of Evidence for Recommendations

" The strength of the evidence for each recommendation in this practice guideline was evaluated based on the previous guideline recommendations and new evidence reviewed and a recommendation grade was determined by the panel. The recommendation grade summarizes the strength of the supporting evidence for acute pain in older adults. Recommendation grades range from A to E on an ordinal scale (with more rigorous study design receiving a higher evidence grade).
Evidence grades are as follows:
A: There is evidence of well-designed meta-analysis in older adults.
B: There is evidence of well-designed controlled trials in the older adult population; randomized and nonrandomized, well-designed quasi-experimental and cohort studies in older adult populations with results that consistently support a specific action (e.g., assessment, intervention or treatment).
C: There is evidence of observational studies (e.g., correlational, descriptive studies) or controlled trials in older adults with inconsistent results.
D: There is evidence of integrative reviews, national clinical practice guidelines, or acute pain research in adults but not specific to older adults.
E: There is evidence of expert opinion or multiple case reports regarding older adults.

Although there is no simple formula for summarizing the evidence, this grading scheme rates studies with more rigorous study design higher. The scheme also gives greater weight to studies conducted on older adults. For example, recommendation grades A-C require support from at least one study conducted in older adults. Moreover, studies with poor internal validity were excluded.
The strength of evidence recommendation grades are provided throughout the guideline following recommendations and references indicated with a **BOLD CAP LETTER.** "

Horgas et al_2008 Horgas A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
"Methods Used to Assess the Quality and Strength of the Evidence Weighting According to a Rating Scheme (Scheme Given) Rating Scheme for the Strength of the Evidence Levels of Evidence Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews) Level II: Single experimental study (randomized controlled trials [RCTs]) Level III: Quasi-experimental studies Level IV: Non-experimental studies Level V: Care report/program evaluation/narrative literature reviews Level VI: Opinions of respected authorities/Consensus panels Reprinted with permission from Springer Publishing Company: Capezuti, E., Zwicker, D., Mezey, M. & Fulmer, T. (Eds). (2008) Evidence Based Geriatric Nursing Protocols for Best Practice, (3rd ed). New York: Springer Publishing Company."
Methods Used to Formulate the Recommendations Expert Consensus Description of Methods Used to Formulate the Recommendations Not stated

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing). (S. 2)
The Universitty of Iowa college of Nursing / John A. Harford Center of Geriatric Nursing Excellence Scheme for Grading the Strength and Consistiency of Evidence in the Guideline
"Evidence-based practice guidelines are developed from several sources of evidence, such as research findings, case reports and expert opinion. The practice recommendations are assigned an evidence grade based upon the type and strength of evidence from research and other literature."
"The grading schema used to make recommendations in this evidence-based practice guideline is: A = Evidence from well-designed meta-analysis. B = Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention or treatment). C = Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results. D = Evidence from expert opinion or multiple case reports"

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement. (S. 31)
Interpretation of Evidence: "Best practice demands that nurses be guided by best available evidence. In order to have the reader understand the strength of the evidence, each recommendation has been cited with a grade of recommendation. The grading system used in this guideline has been adapted from the Scottish Intercollegiate Guideline Network (2000)."

Grades of Recommendations:
"A Requires at least one randomized controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendations. This grade may include systematic review and/or meta-analysis of randomized controlled trials."
"B Requires the availability of well conducted clinical studies, but no randomized clinical trials on the topic of the recommendation. This includes evidence from well-designed controlled studies without randomization, quasi-experimental studies, and non-experimental studies such as comparative studies, correlation studies, and case studies. The RNAO guideline development panel strongly supports the inclusion of well-designed qualitative studies in this category."
"C Requires evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities. Indicates an absence of directly applicable clinical studies of good quality."

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen. (S. 3 / Deel I & S. 106 / Deel II)	
"Een belangrijk dilemma dat de werkgroep heeft ervaren, is dat er nog onvoldoende onderzoek is naar de effectiviteit van diagnostische- en behandelstrategieën bij de groep kwetsbare ouderen. Dit heeft ervoor gezorgd, dat de werkgroep regelmatig ook 'indirect' of afgeleide evidence en ook expert-opinion moest gebruiken bij het formuleren van de aanbevelingen. Er bestaan meer dan twintigduizend publicaties over pijn bij ouderen. Daarom heeft de werkgroep zich beperkt tot de signalering en behandeling van chronische pijn in langdurige behandelrelaties. Dat betekent dat voor invasieve pijnbestrijding zoals zenuwblokkades verwezen wordt naar de expertise van pijnconsulenten in de ziekenhuizen. Voor pijnbestrijding bij kanker en in de palliatieve fase wordt. verwezen naar de richtlijnen van de Vereniging van Integrale Kankercentra."	
Onderstaand classificatieschema is door hen gehanteerd:	
High	"Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes (≥2 consistent, higher-quality randomized controlled trials or multiple, consistent observational studies with no significant methodological flaws showing large effects)."
Moderate	"Evidence is sufficient to determine effects on health outcomes, but the number, quality, size, or consistency of included studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes (≥1 higher quality trial with >100 subjects; ≥2 higher quality. Trials with some inconsistency; ≥2 consistent, lower-quality trials; or multiple, consistent observational studies with no significant methodological flaws showing at least moderate effects) limits the strength of the evidence."
Low	"Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higherquality studies, important flaws in study design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes."
Strength of recommendation	
Strong	"Benefits clearly outweigh risks and burden OR risks and burden clearly outweigh benefits."
Weak	"Benefits finely balanced with risks and burden."
Insufficient	"Insufficient evidence to determine net benefits or risks"

5 Leitliniensynopse

In diesem Kapitel werden die Originalzitate zur Beantwortung der klinisch relevanten Fragen dargelegt, die in einem Delphi-Verfahren mit den Delegierten der beteiligten Fachgesellschaften und Interessensgruppen konsentiert wurden. Dabei wurden 38 Fragen in den Bereichen Screening, Assessment und Verlaufskontrolle von Schmerz definiert, die in Tabelle 6 ausgeführt werden.

Tabelle 6: Übersicht der klinisch relevanten Fragen

I) Screening von Schmerz
Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Frage 4: Inwieweit ist ein zu benennender retrospektiver Zeitraum für die Einschätzung der Auskunftsfähigkeit zu berücksichtigen?
Frage 5: Welchen Nutzen hat ein Screening im Vergleich zu keinem Screening für die ausgewählte Population?
Frage 6: Nach welchem Schmerz (z.B. behandlungsnotwendiger Schmerz, Schmerz in der Anamnese etc.) wird gescreent?
Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Frage 9: Welchen Zeitraum (aktuell und / oder zurückliegend) sollte das Screening erfassen?
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Frage 11: Wie oft sollte ein Screening stattfinden?
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Frage 13: Welchen Nutzen haben Screeninginstrumente hinsichtlich der Versorgungsqualität der Bewohner
Frage 14: Wer sollte nach Schmerzen screenen?
Frage 15: Welche Konsequenz sollte das Screening der Bewohner haben?
Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Frage 17: Wie sollte das Screening dokumentiert werden?
II) **Assessment von Schmerz**
Frage 18: Welchen Nutzen hat ein Assessment von Schmerzen im Vergleich zu keinem Assessment für die ausgewählte Population?
Frage 19: Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Frage 21: Wie können diese Informationen gewonnen werden?
Frage 22: Welche Schmerzerfassungsinstrumente sind geeignet?
Frage 23: Welche Präferenzen haben Bewohner hinsichtlich der Behandlung oder Nicht-Behandlung von Schmerzen?
Frage 24: Wer sollte das Schmerzassessment durchführen?
Frage 25: Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?
Frage 26: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Frage 27: Wie zeitstabil muss das Ergebnis des Schmerzassessments sein?
Frage 28: Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Frage 29: Wie sollte das Schmerzassessment dokumentiert werden?
Frage 30: Wann sollte ein Assessment von Schmerzen stattfinden?
III) Verlaufserfassung von Schmerz Verlaufserfassung wird im Sinne von Follow UP, Schmerzassessment nach Therapie, Abschluss einer Schmerztherapie und ohne Therapie von Schmerz verstanden. Therapie wird sowohl als medikamentös und nicht medikamentösen Maßnahme verstanden.
Frage 31: Welche Kriterien müssen erfüllt sein, damit eine Verlaufserfassung durchgeführt werden kann?
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Frage 33: Welchen Nutzen hat eine Verlaufserfassung von Schmerzen im Vergleich zu keiner

Verlaufserfassung für die ausgewählte Population?
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Frage 36: Wer sollte diese Informationen erfassen?
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?

Dabei wurden die englischsprachigen Originalzitate im Original belassen, die niederländischen teilweise sinngemäß zusätzlich übersetzt. Ausgewiesen werden darüber hinaus jeweils der Name der Quell-Leitlinie, die klinisch relevante Frage, die Seitenzahl auf der das Zitat gefunden wurde, Angaben zum explizit ausgewiesenen Evidence-Grad Empfehlungsstärke sowie die ausgewiesenen Referenzen zum Zitat.
Bei der Konsentierung der klinisch relevanten Fragen ergab sich aus technischen Gründen der Beginn der Nummerierung der Fragen mit der Nummer 2. Diese Reihenfolge wurde für diese Synopse beibehalten, so dass auch hier die Nummerierung der Fragen mit 2 beginnt und mit der Frage 39 endet. In den einzelnen Originalzitaten sind jeweils ausgewiesene Evidenz Empfehlungsgrade farblich markiert, desgleichen das Publikationsdatum der ausgewiesenen Literatur.

5.1 Zitate zur Beantwortung der klinisch relevanten Fragen zum Bereich Screening von Schmerz bei älteren Menschen in der vollstationären Altenhilfe

Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities long-term care facilities.
Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?
Seite: 106
Zitat (in Originalsprache): “Cognitive status was assessed using the Modified Mini-Mental Status Examination (MMSE), 36 a widely used measure of cognitive function; the average MMSE score of the participants was 12.1/30.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Tombaugh, T.N., McIntyre, N.J. (1992). The mini-mental state examination: a comprehensive review. J Am Geriatr Soc; 40: S. 922–935.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities. long-term care facilities.
Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?
Seite: 107
Zitat (in Originalsprache): “Determine if Mini Mental Status Examination scores are available or can be obtained. This would facilitate determination of patient ability to provide valid self-report.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1–S43. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs; 7: S. 44-52. doi:10.1016/j.pmn.2006.02.003

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23 (1): S1-S43.
Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?
Seite: S8
Zitat (in Originalsprache): “Cognitive Status Evaluation An evaluation of the patient’s cognitive function is crucial to the identification of an appropriate pain assessment strategy and to the development of an appropriate treatment plan. It may also be a critical treatment outcome measure. Mounting evidence indicates that both acute and chronic pain can impact cognitive status, [29–31] and hat for patients with acute pain, cognitive function should return to normal after the successful pain treatment. The reversibility of cognitive dysfunction in patients with chronic pain is unknown. Cognitive function can be evaluated by questioning patients and their amilies and

caregivers on the presence of memory impairment, apraxia or aphasia, as well as their functional impacts. A Mini-Mental State Examination (MMSE) test is one brief, standardized way to screen cognitive function.
Practitioners should be aware, however that the MMSE is not a perfect test and that highly educated individuals with dementia may score within the normal range. Conversely, those with very low educational status may score within the dementia range. The clock drawing test is a complementary method of screening for dementia [33,34].
If these screening tests suggest the presence of dementia, more detailed neuropsychologic testing should be pursued."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[32.] Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975). Mini-mental state. A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research; 12 (3): S. 189-198.
[33.] Shulman, K. (2000). Clock-drawing: is it the ideal cognitive screening test? Int J Geriatr Psychiatry; 15: S. 548–561.
[34.] Tuokko, H., Hadjistavropoulos, T., Miller, J.A. et al. (1995). The Clock Test: Administration and Scoring Manual. Toronto, Ontario: Multi-Health Systems.

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?

Seite: 18

Zitat (in Originalsprache):
"Assess cognitive status of older adult patients. Screen for cognitive impairment using reliable tools. Differentiate between delirium and dementia as managing pain and other aspects of care may vary depending on condition. The cognitive status of the older adult will impact approach to pain assessment, patient and family education, as well as pain treatment options. A baseline assessment of cognitive status will provide a basis for evaluating changes in cognitive status throughout the period of illness. Older adults are at risk for development of delirium post-trauma (e.g., hip fracture) or post-operatively, a serious complication requiring careful evaluation and treatment. Pain may be a contributing factor."

Evidence-Grad: siehe Referenzen II-a -V
Empfehlungsstärke: B - C

Referenzen:
AGS (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a)
Gustafson, Y., Brännström, B., Norberg, A., Gustav, B., Winbald, B. (1991). Underdiagnosis and poor documentation of acute confusional states in elderly hip fracture patients. Journal of the American Geriatrics Society; 39: S. 760-765. (II-a)
Kane, R.L., Ouslander, J.G., Abrass, I.B. (2004). Drug therapy. In R.L. Kane, J.G. Oulander, I. B. Abrass (ed.). Essentials of Clinical Geriatrics; 5th ed. S: 357-388). New York: McGraw-Hill. (V)
Miller, J., Neelon, V., Dalton, J., Ng'andu, N., Bailey, D., Jr., Layman, E., Hosfeld, A. (1996). The assessment of discomfort in elderly confused patients: A preliminary study. Journal of Neuroscience Nursing; 28 (3): S: 175-182. (III-a)
Naylor, M.D., Stephens, C., Bowles, K.H., Bixby, M.B. (2005). Cognitively impaired older adults: from hospital to home. American Journal of Nursing; 105 (2): S. 52-61. (III-a).
Parikh, S.S., Chung, F. (1995). Postoperative delirium in the elderly. Anaesthesia & Analgesia; 80: S. 1223-1232. (IV-a).
Strömberg, L., Lindgren, U., Nordin, C., Öhlen, G., Svensson, O. (1997). The appearance and disappearance of cognitive impairment in elderly patients during treatment for hip

fracture. Scandinavian Journal of Caring Science; 11: S. 167-175. (III-a)
Duggleby, W., Lander, J. (1994). Cognitive status and postoperative pain: Older adults. Journal of Pain & Symptom Management; 9 (1): S. 19-27. (III-a)

Dazu sind Instrumente empfohlen:
The **Mini Mental State Examination (**Folstein et al., 1975) has been shown to be a reliable measure of cognitive impairment (Naylor et al., 2005; Tombaugh & McIntyre,1992). **—B**

- The **Six-Item Mental Status Screener (**Callahan et al., 2002) is a short simple screening tool that requires minimal time to complete and correlates with other more formal assessment approaches (Callahan et al., 2002).—**C** (See Appendix G)

- The **Confusion Assessment Method (**Inouye et al., 1990) has been shown to be a reliable measure of delirium in older adults (Laurila et al., 2002; Schuurmans et al.,2003).**—B**

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?

Seite: 19

Zitat (in Originalsprache):
“Ask the family for information on cognitive status. The family may provide vital information regarding cognitive impairment of the patient.”

Evidence-Grad: siehe Referenzen III-a & IV-a
Empfehlungsstärke: **B**

Referenzen:
Herr, K., Garand, L. (2001). Assessment and Measurement of Pain in Older Adults. Clinics in Geriatric Medicine; 17 (3): S: 457-478. (IV-a)
Jorm, A.F. (2004). The Informant Questonnaire on Cognitive Decline in the Elderly (IQCODE): a review. International Psychogeriatrics; 16 (3): S. 1-19. (IV-a)
Naylor, M.D., Stephens, C., Bowles, K.H., Bixby, M.B. (2005). Cognitively impaired older adults: from hospital to home. American Journal of Nursing; 105 (2): S. 52-61. (III-a)

Dazu ist ein Instrument empfohlen:
The **Informant Questionnaire on Cognitive Decline in the Elderly (Short IQCODE) (**Jorm, 1994) has been shown to be a reliable tool for assessing cognitive status in older persons using information provided by the family or caregiver (Jorm,1994, 2004).—**B**

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?

Seite: 67

Zitat (in Originalsprache):
“The following procedure is suggested:
1. Screen for cognitive impairment with a validated tool. Screening tool selection is made based on the situation:
¾ Six-Item Screener (Callahan et al., 2002) may be used to screen for cognitive impairment in the emergency or acute situation (e.g., emergency department or postanesthesia car unit). This short screen requires less energy expenditure and the older person is not required to write. Scores range from 0 to 6 and a score of three or more errors indicates cognitive impairment. However, the Mini-Mental Status Examination has better sensitivity and is preferred when possible.

¾ The Mini-Mental Status Examination (MMSE) (Folstein et al., 1975) a widely used, valid and reliable tool for screening for cognitive impairment. This tool may be found in many texts and articles.
• A score of 23 or less suggests cognitive impairment. Because the tool favors individuals who have achieved a higher educational level, an alternative scoring system has been developed as follows:
− a middle school education: a score of 21 or less
− a high school education: a score of 23 or less
− a college or graduate school education: a score of 24 or less (Uhlmann & Larson, 1991)
2. If the older adult has a positive score on the MMSE suggesting cognitive impairment, screen for delirium using the Confusion Assessment Method (CAM) (Inouye et al., 1990). If the older adult has a positive score on the CAM, treatment should be initiated promptly.
3. If the older adult has a borderline score or less on the MMSE, further screening using the Informant Questionnaire on Cognitive Decline n the Elderly (IQCODE) (Jorm, 2004) is recommended. This tool involves a structured interview of a family member who knows the older person well. “

Evidence-Grad: siehe Referenzen III-a - IV-a
Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Callahan, C.M., Unverzagt, F.W., Hui, S.L., Perkins, A.J., Hendrie, H.C. (2002). Six-item screener to identify cognitive impairment among potential subjects for clinical research. Medical Care; 40 (9): S. 771-781. (III-a)
Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975). Mini-mental state. A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research; 12 (3): S. 189-198. (III-a)
Inouye, S.K., van Dyck, C.H., Alessi, C.A., Balkin, S., Siegal, A.P., Horwitz, R.I. (1990). Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Annals of Internal Medicine; 113 (12): S. 941-948. (III-a)
Jorm, A.F. (2004). The Informant Questonnaire on Cognitive Decline in the Elderly (IQCODE): a review. International Psychogeriatrics; 16 (3): S. 1-19. (IV-a)
Uhlmann, R.F., Larson, E.B. (1991). Effect of education on the mini-mental state examination as a screening test for dementia. Journal of the American Geriatrics Society, 39 (9): S. 876-880. (III-a)

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 2: Wie lässt sich "uneingeschränkt auskunftsfähig" und "nicht auskunftsfähig" definieren?

Seite: 28

Zitat (in Originalsprache):
„De informatie die ouderen zelf geven over hun pijn wordt ook wel zelfrapportage genoemd. selfrapportage van pijn door kwetsbare ouderen met een cognitieve beperking is niet minder valide dan die van ouderen zonder cognitieve beperkingen (Parmelee et al, 1993). Wel kan bij dementie het vermogen om een pijnlijke stimulus te interpreteren aangetast zijn (zie hoofdstuk 2 en Scherder et al, 2005). Gebaseerd op de literatuur kan worden gesteld dat patiënten met een Mini Mental Status Examination (MMSE) van 18 en hoger op een valide en betrouwbare manier pijn kunnen aangeven met behulp van een zelfrapportage instrument (Jensen et al, 1998; Weiner et al, 1999a; Scherder & Bouma , 2000; Chibnall & Tait, 2001). Scherder & Bouma constateerden ook dat nog 80% van de mensen met een MMSE lager dan 18 in ieder geval één specifieke pijnschaal begreep. Een enkele studie vermeldt valide zelfrapportage bij een MMSE score van 12 of hoger
(Ferrell et al, 1995). Bij kwetsbare ouderen met cognitieve/communicatieve beperkingen moet daarnaast observatie plaatsvinden van potentiële lichamelijke, psychische, fysiologische en gedragsmatige pijnindicatoren en geluisterd worden naar signalen van

verzorgenden en mantelzorgers.
Empfehlung dazu:
– Zelfrapportage van pijn is voor kwetsbare ouderen zonder of met milde tot matige cognitieve/communicatieve beperkingen de gouden standaard om pijn te identificeren.“

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

Jensen, M.P., Miller, L., Fisher, L.D. (1998). Assessment of pain during medical procedures: a comparison of three scales. Clin J Pain.; 14 (4): S. 343-349.
Weiner, D.K., Peterson, B., Ladd, K., McConnell, E.R.N., Keefe F. (1999a). Pain in nursing home residents: An exploration of prevalence, staff perspectives and practical aspects of measurement. Clinical Journal of Pain; 15 (2): S. 92-101.
Scherder, E.J.A., Bouma, A. (2000). Visual Analogue scales for pain assessment in Alzheimer’s Disease. Gerontology; 46: S. 47-53.
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173-186.

Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 205
Zitat (in Originalsprache): “A high prevalence of dementia, sensory impairments, and disability in this population make assessment and management more difficult.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
S: 210
Zitat (in Originalsprache): “D. Initial assessment should include evaluation of psychologic function, including mood (e.g., depression, anxiety), self-efficacy, pain coping skill, helplessness, and pain-related fears. (IIA) F. Cognitive function should be evaluated for new or worsening confusion. (IIA)”
Evidence-Grad: II Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 4
• “The recognition and assessment or evaluation of pain in elderly LTC patients can be complicated by factors such as an atypical presentation of pain, cognitive and communication barriers, and patient perception. “ • “Patients may be unable to report feeling pain or to respond to caregivers' questions about pain because of cognitive or sensory impairments or difficulties with language or speech. “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005). Pain in Residential Aged Care Facilities – Management Strategies.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 2
Zitat (in Originalsprache): “KNOWN BARRIERS TO ACCURATE PAIN IDENTIFICATION Cognitive and communicative impairments

-Dementia	-Hearing and vision loss
-Dysphasia	-Dysarthria”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen	
Referenzen: nicht ausgewiesen	

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 4
Zitat (in Originalsprache): “In people with difficulty in communication (including cognitive impairment) and in situations where procedures might cause pain, an observational assessment is additionally required.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 6
Zitat (in Originalsprache): “Assessing pain becomes even more challenging in the presence of severe cognitive impairment, communication difficulties or language and cultural barriers. Older people with severe cognitive impairment can find it difficult to articulate their pain and their ability to self-report can become impaired or absent. Instead, behavioral reactions may be the only available externally observable sign of pain**.** Behavioural reactions are difficult to interpret. It is particularly important that pain is considered as a possible underlying cause for behavioural change and those steps are taken to pinpoint the cause. Even in the presence of moderate cognitive impairment, when a person can communicate about their pain, their self-reports have been shown to be valid.[16, 17]**”**
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [16.] Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173-186. [17.] Parmelee, P.A., Smith, B., Katz, I.R. (1993). Pain complaints and cognitive status among elderly institution residents. Journal of the American Geriatrics Society; 41: S. 517-522.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 18
Zitat (in Originalsprache): “Cognitively impaired older people under report pain. However, when older people with cognitive impairment report pain, their self-reports of pain are no less valid than those of cognitively intact individuals[17].”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [17.] Parmelee, P.A., Smith, B., Katz, I.R. (1993). Pain complaints and cognitive status among elderly institution residents. Journal of the American Geriatrics Society; 41: S. 517-522.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities. long-term care facilities.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 107
Zitat (in Originalsprache): “Determine if Mini Mental Status Examination scores are available or can be obtained. This would facilitate determination of patient ability to provide valid self-report.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: in Tbl. 1direkter Bezug nicht erkennbar. Dort wird auf zwei Ref. verwiesen, die auch nur Empfehlungscharakter vermuten lassen Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1–43. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs; 7: S. 44–52. doi:10.1016/j.pmn.2006.02.003

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., K. Herr, et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23 (1): S1-43.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: S1
Zitat (in Originalsprache): “Nonetheless, pain problems are often overlooked, under-assessed, and misassessed, especially among seniors with dementia.[5,6]”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [5.] Martin, R., Williams, J., Hadjistavropoulos, T. et al. (2005). A qualitative investigation of seniors’ and caregivers’ views on pain assessment and management. Can J Nurs Res; 37: S. 142–164. [6.] Sengstaken, E.A., King, S.A. (1993). The problems of pain and its detection among geriatric nursing home residents. J Am Geriatr Soc; 41: S. 541–544.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., K. Herr, et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23 (1): S1-43.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: S8
Zitat (in Originalsprache): “An evaluation of the patient’s cognitive function is crucial to the identification of an appropriate pain assessment strategy and to the development of an appropriate treatment plan. It may also be a critical treatment outcome measure. Mounting evidence indicates that both acute and chronic pain can impact cognitive status,[29–31] and that for patients with acute pain, cognitive function should return to normal after the successful pain treatment. The reversibility of cognitive dysfunction in patients with chronic pain is unknown.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [29.] Eccleston, C., Crombez, G., Aldrich, S. et al. (1997). Attention and somatic awareness in chronic pain. Pain; 72: S. 209–215. [30.] Morrison, R.S., Magaziner, J., Gilbert, M. et al. (2003). Relationship between pain and

opioid analgesics on the development of delirium following hip fracture. J Gerontol Series A Biol Med Sci; 58: S. 76–81.
[31.] Weiner, D.K., Sakamoto, S., Perera, S. et al. (2006). Chronic low back pain in older adults: prevalence, reliability, and validity of physical examination findings. J Am Geriatr Soc; 54: S. 11–20.

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?

Seite: 4-5

Zitat (in Originalsprache):
“Frail older adults who suffer from severe dementia and other forms of cognitive impairment who are unable to verbally express their pain are at particularly high risk for poor pain assessment and management (Ardery et al., 2003; Feldt et al., 1998a; Morrison et al., 2003a; Morrison & Siu, 2000).”

Evidence-Grad: siehe Referenzen II-a – V-a
Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Adunsky, A., Levy, R., Mizrahi, E., Arad, M. (2002b). Exposure to opioid analgesia in cognitively impaired and delirious elderly hip fracture patients. Archives of Gerontology & Geriatrics; 35 (3): S. 245-251. (III-a).
Ardery, G., Herr, K.A., Titler, M.G., Sorofman, B.A., Schmitt, M.B. (2003). Assessing and managing acute pain in older adults: a research base to guide practice. MEDSURG Nursing; 12 (1): S. 7-19. (V-a).
Bell, M.L., Reeves, K.A. (1999). Postoperative pain management in the non-Hispanic White and Mexican American older adult. Seminars in Perioperative Nursing; 8 (1): S. 7-11. (III-a).
Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a).
Ferrell, B.R., Ferrell, B.A. (ed.) (1996). Pain in the elderly. Seattle, WA: IASP Press, International Association for the Study of Pain. (V-a).
Green, C.R., Anderson, K.O., Baker, T.A., Campbell, L.C., Decker, S., Fillingim, R.B., Kalauokalani, D.A., Lasch, K.E., Myers, C., Tait, R.C., Todd, K.H., Vallerand, A.H. (2003a). The unequal burden of pain: confronting racial and ethnic disparities in pain. Pain Medicine; 4 (3): S. 277-294. (V-a).
Green, C.R., Baker, T.A., Smith, E. M., Sato, Y. (2003b). The effect of race in older adults presenting for chronic pain management: a comparative study of black and white Americans. Journal of Pain; 4 (2): S.82-90. (III-a).
Green, C.R., Ndao-Brumblay, S.K., Nagrant, A.M., Baker, T.A., Rothman, E. (2004). Race, age, and gender influences among clusters of African American and white patients with chronic pain. Journal of Pain; 5 (3): 171-182. (III-a).
Horgas, A.L., Tsai, P. (1998). Analgesic drug prescription and use in cognitively impaired nursing home residents. Nursing Research; 47 (4): S. 235-242. (III-a).
Kaasalainen, S., Middleton, J., Knezacek, S., Hartley, T., Stewart, N., Ife, C., Robinson, L. (1998). Pain and cognitive status in the institutionalized elderly: Perceptions and interventions. Journal of Gerontological Nursing; 24 (8): S. 24-31. (III-a).
Manfredi, P.L., Breuer, B., Wallenstein, S., Stegmann, M., Bottomley, G., Libow, L. (2003b). Opioid treatment for agitation in patients with advanced dementia. International Journal of Geriatric Psychiatry; 18 (8): S. 700-705. (II-a).
McNeill, J.A., Sherwood, G.D., Starck, P.L. (2004). The hidden error of mismanaged pain: a systems approach. Journal of Pain & Symptom Management; 28 (1): S. 47-58. (III-b).
Miller, L.L., Talerico, K.A. (2002). Pain in older adults. Annual Review of Nursing Research.

(IV-a).
Morrison, R.S., Siu, A.L. (2000). A Comparison of Pain and its Treatment in Advanced Dementia and Cognitively intact patients with Hip Fracture. Journal of Pain & Symptom Management; 19 (4): S. 240-248. (III-a).
Morrison, R.S., Magaziner, J., Gilbert, M., Koval, K. J., McLaughlin, M. A., Orosz, G., Strauss, E., Siu, A. L. (2003a). Relationship between pain and opioid analgesics on the development of delirium following hip fracture. Journals of Gerontology Series A-Biological Sciences & Medical Sciences; 58 (1): S. 76-81. (II-a).
Rakel, B., Herr, K. (2004). Assessment and treatment of postoperative pain in older adults. Journal of Perianesthesia Nursing; 19 (3): S. 194-208. (IV-a).
Todd, K.H., Deaton, C., D'Adamo, A.P., Goe, L. (2000). Ethnicity and analgesic practice. Annals of Emergency Medicine; 35: S. 11-16. (III-b).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?

Seite: 9

Zitat (in Originalsprache):
“Older adults with cognitive impairment such as delirium and severe dementia may not be able to self-report pain and have special pain assessment needs. These needs and recommendations for pain assessment strategies are addressed in a separate subsection and are meant to supplement and augment the recommendations made in other sections of the guideline. (See Pain Assessment and Management Plan.)”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?

Seite: 9

Zitat (in Originalsprache):
“Pain assessment is a critical component of a comprehensive approach to acute pain management of older adults. The scope and nature of the pain assessment will depend on a number of factors such as the physiological stability of the patient, whether the situation is an emergency or planned event (VHA/DoD, 2002).”

Evidence-Grad: siehe Referenzen IV-b
Empfehlungsstärke: nicht ausgewiesen

Referenzen:
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 3
Zitat (in Originalsprache): “In het bijzonder zijn herkenning en behandeling van chronische pijn niet optimaal bij ouderen met cognitieve en communicatieve beperkingen door comorbide aandoeningen zoals CVA, dementie, multiple sclerose of de ziekte van Parkinson (Achterberg et al, 2007). “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Achterberg, W.P., Scherder, E., Pot, A.M., Ribbe, M.W. (2007). Cardiovascular risk factors in cognitively impaired nursing home patients: a relationship with pain? Eur J Pain; 11 (6): S. 707-710.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 19
Zitat (in Originalsprache): “Patiënten met frontotemporale dementie (FTD) signaleren pijnlijke stimuli minder goed dan ouderen met Alzheimer of met vasculaire dementie (Raadsheer et al, 1995).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Raadsheer, F.C., Van Heerikhuize, J.J., Lucassen, P.J., Hoogendijk, W.J.G., Tilders, F.J.H., Swaab, D.F. (1995). Corti-cotropin-releasing hormone mRNA levels in the paraventricular nucleus of patiënts with Alzheimer’s disease and depression. Am J Psychiatry; 152: S. 1372-1376.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 3: Inwieweit ist der gegenwärtige gesundheitliche Zustand des Bewohners / der Bewohnerin zur Erfassung der Auskunftsfähigkeit zu Schmerz relevant?
Seite: 33ff.
Zitat (in Originalsprache): „3.2.5 De gevolgen van pijn bepalen Pijn is geassocieerd met een slechte algemene conditie, depressie, slaapstoornissen en een verminderde kwaliteit van leven (Ross, 1998). De combinatie van veel pijn, chronische angst en depressie (chronisch pijnsyndroom) lijkt bij ouderen minder vaak voor te komen dan bij jonge volwassenen en volwassenen van middelbare leeftijd. Ze vormen een buitengewoon heterogene groep: sommigen hebben minder pijn, minder last van een depressie en blijven actief, anderen hebben veel pijn met veel effect op hun functioneren. Anderen laten meer een middenweg hierin zien (Corran et al, 1997; Weiner et al, 2001; Hall-Lord et al, 1999).“ „3.2.5.1 – Stemming Met behulp van de Geriatrische Depressie Schaal (GDS-15) kan nagegaan worden of er mogelijk van een depressieve stemming sprake is (Vinkers et al, 2004). De GDS is een screenings-instrument dat zich leent voor het screenen van depressie bij ouderen op basis van zelfrapportage. De inhoud van de vragen heeft echter wel overlap met sommige symptomen van chronische pijn (zoals bijv. minder activiteiten kunnen ondernemen of minder energie ervaren) en de gebruiker zal dus bij de interpretatie voorzichtig moeten zijn over de bijdrage van dergelijke items aan de totaal score en de conclusie die daar

vervolgens uitgetrokken moet worden. Als kwetsbare ouderen cognitieve stoornissen hebben die dusdanig ernstig zijn dat zelfrapportage gehinderd wordt, dan zal overgegaan moeten worden tot gedragsobservatie. Volgens Vinkers et al (2004) zijn alleen betrouwbare uitkomsten te verkrijgen als de MMSE-score boven de 18 ligt. Voor verpleeghuisbewoners is een GDS-8 ontwikkeld met goede psychometrische eigenschappen. De GDS-8 is minder belastend voor de patiënt, gemakkelijker te gebruiken en vergt minder tijd dan de GDS-15 (Jongenelis et al, 2007).“

„3.2.5.2 – Cognitie

Neuronale circuits en hun hersengebieden die een rol spelen bij cognitieve functies zoals het geheugen en executieve functies (bijvoorbeeld het frontohippocampale circuit) zijn ook sterk betrokken bij het verwerken van de motivationele- affectieve componenten van pijn, bij de cognitief-evaluatieve aspecten van pijn en bij de autonome reacties op pijn. Door middel van neuropsychologisch onderzoek is het mogelijk de kwaliteit van deze cognitieve functies te testen en daarmee mogelijk een indirecte inschatting te maken van het functioneren van de onderliggende neuronale circuits die dus ook een rol spelen bij de beleving van pijn. Neuropsychologisch onderzoek geeft inzicht in de kwaliteit van verschillende cognitieve functies. Deze cognitieve functies zijn weer afhankelijk van het functioneren van neurale circuits die ook essentieel zijn voor de verwerking van pijn. Hierbij kan gedacht worden aan neurale circuits die behoren tot het mediale pijnsysteem. Inzicht in de kwaliteit van cognitieve functies door een neuropsychologisch onderzoek kan een indirecte maat betekenen voor het functioneren van neurale circuits die behoren tot het mediale pijnsysteem. Op deze wijze kann neuropsychologisch onderzoek een bijdrage leveren aan de diagnostiek van pijn. Deze aanvullende diagnostiek is van groot belang voor het verder uitbouwen van de kennis over pijn, en wordt dan ook met name aanbevolen voor (academische) centra die gespecialiseerd zijn op pijn bij dementie, of in het kader van wetenschappelijk onderzoek. Vooralsnog is het directe belang voor de patiënt te gering, om het als gebruikelijke diagnostiek te adviseren.“

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

AGS (2002). Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224.

Corran, T.M., Farrell, M.J., Helme, R.D., Gibson, S.J. (1997). The classification of patients with persistent pain: Age as a contributing factor. Clinical Journal of Pain; 13 (3): S. 207-214.

Weiner DK, Rudy TE, Gaur S. (2001). Are all older adults with persistent pain created equal? Preliminary evidence for a multiaxial taxonomy. Pain Research & Management; 6 (3): S. 133-141.

Hall-Lord, M.L., Larsson, G., Steen, B. (1999). Persistent pain and distress in older people: a cluster analysis. International Journal of Nursing Practice; 5: S. 78-85.

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Yohannes, A.M., Roomi, J., Waters, K., Connolly, M.J. (1997). A comparison of the Barthel index and Nottingham extended activities of daily living scale in the assessment of disability in chronic airflow limitation in old age. Age and Ageing; 27: S. 369-74.

Dyer, C.A.E., Singh, S.J., Stockley, R.A., Sinclair, A.J., Hill, S.L. (2002). The incremental shuttle walking test in elderly people with chronic airflow limitation. Thorax; 57: S. 34-8.

Nouri, F.M., Lincoln, N.B. (1987). An extended activities of daily living scale for stroke patients. Clinical Rehabilitation; 1: S. 301-305.

Mahoney, F.I., Barthel, D.W. (1965). Functional evaluation: The Barthel Index. Maryland State Medical Journal; 14: S. 61-65

HARM-WRESTLING (2009). VWS: 7.

De Haan R, Limburg M, Schuling J, Broeshart J, Jonkers L, van Zuylen P. (1993). Klinimetrische evaluatie van de Barthel-index, een maat voor beperkingen in het dagelijks functioneren. Ned Tijdschr Geneeskd; 137 (18): S. 917-921.

Jongenelis, K., Gerritsen, D.L., Pot, A.M., Beekman, A.T., Eisses, A.M., Kluiter, H., Ribbe, MW. (2007). Construction and validation of a patiënt- and user-friendly nursing home version of the Geriatric Depression Scale. Int J Geriatr Psychiatry; 22 (9): S. 837-842.

Frage 4: Inwieweit ist ein zu benennender retrospektiver Zeitraum für die Einschätzung der Auskunftsfähigkeit zu berücksichtigen?

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 4: Inwieweit ist ein zu benennender retrospektiver Zeitraum für die Einschätzung der Auskunftsfähigkeit zu berücksichtigen?
Seite: 19
Zitat (in Originalsprache): **"Ask about pain in the present.** Older adults with memory impairment may often be able to report reliably in the here and now, but have difficulty remembering past pain experiences, including their earlier ratings of pain"
Evidence-Grad: siehe Referenzen III-a – IV-a Empfehlungsstärke: B
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a). Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patients. Aging-Clinical & Experimental Research; 12 (5), S. 380-387. (III-a). Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a). Miller, J., Neelon, V., Dalton, J., Ng'andu, N., Bailey, D., Jr., Layman, E., Hosfeld, A. (1996). The assessment of discomfort in elderly confused patients: A preliminary study. Journal of Neuroscience Nursing; 28 (3): S: 175-182. (III-a).

Frage 5: Welchen Nutzen hat ein Screening im Vergleich zu keinem Screening für die ausgewählte Population?

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 5: Welchen Nutzen hat ein Screening im Vergleich zu keinem Screening für die ausgewählte Population?
Seite: 14
Zitat (in Originalsprache): **"Establish a comfort-function goal with the patient.** A comfort-function goal is used postoperatively to achieve and maintain adequate pain control. This should be established preoperatively by asking the patient to identify a level of pain that makes it easy to perform needed recovery activities that may be painful, such as coughing and deep breathing. Patients who are able are then asked to select the pain rating (e.g., on a scale of 0 to 10) that will make it easy to cough and deep breathe. Ratings of 4/10 or greater interfere significantly with function and above a 5 adversely affect quality of life. Explaining this to the patient helps him/her set realistic goals (Cepeda et al., 2003a; Pasero & McCaffery, 2004b).—"
Evidence-Grad: siehe Referenzen III-a & V-b Empfehlungsstärke: siehe Zitat und Referenzen: C
Referenzen: Cepeda, M.S., Africano, J.M., Polo, R., Alcala, R., Carr, D.B. (2003a). What decline in pain intensity is meaningful to patients with acute pain? Pain; 105 (1-2): S. 151-157. (III-a). Pasero, C., McCaffery, M. (2004b). Comfort-function goals. American Journal of Nursing; 104 (9): S. 77. (V-b).

Frage 6: Nach welchem Schmerz (z.B. behandlungsnotwendiger Schmerz, Schmerz in der Anamnese etc.) wird gescreent?

AGS 2002 AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 6: Nach welchem Schmerz (z.B. behandlungsnotwendiger Schmerz, Schmerz in der Anamnese etc.) wird gescreent?
Seite: 208
Zitat (in Originalsprache): “(…) assess the patient for evidence of persistent pain.”
Evidence-Grad: II Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?

AGS 2002 AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?
Seite: 210
Zitat (in Originalsprache): “B. Unusual behavior in a patient with severe dementia should trigger assessment for pain as a potential cause. (IIA)”
Evidence-Grad: II Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?
Seite: 3
Zitat (in Originalsprache): “TABLE 1 Some Conditions Associated With the Development of Pain in Elderly People •Cardiopulmonary diseases (myocardial infarction, pulmonary thromboembolism, pleurisy, pericarditis, angina) • Crystal-induced arthropathies (e.g., gout, pseudogout) •Degenerative joint disease (osteoarthritis) •Depression • Fibromyalgia •Gastraintestinal conditions (e.g., constipation, ileus, gastritis, gastroesophageal reflux, peptic ulcers) • Headaches •Immobility, contractures •Infections •Metabolic conditions (e.g., electrolyte abnormalities, vitamin D deficiency) •Neuropathies (e.g., diabetic neuropathy, occipital or trigeminal neuralgia, post-herpetic neuralgia) • Oral or dental pathology •Osteoporosis (compression fractures) •Peripheral arterial disease •Polymyalgia rheumatica or giant cell arteritis (temporal arteritis) •Post-stroke syndromes •Pressure ulcers •Rheumatoid arthritis •Spinal column disorders {cervicalor lumbar spinal stenosis or radiculopathy} •Trauma {fractures, soft tissue injury} •Urogenital conditions {e.g., bladder distention, infection, kidney stones}.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Barkin, R.L., Barkin, S.J. et al. (2005). Perception, assessment, treatment, and management of pain in the elderly. Clin Geriatr Med; 21 (3): S. 465-490. Ferrell, B.A. (1995). "Pain evaluation and management in the nursing home. Ann Intern Med; 123 (9): S. 681-687. American Geriatrics Society Panel on Pharmacological Management of Persistent Pain in Older Persons (AGS) (2009). Pharmacological management of persistent pain in older persons. J Am Geriatr Soc; 57 (8): S. 1331-1346.

American Geriatrics Society Panel on Pharmacological Management of Persistent Pain in Older Persons (AGS) (2002). The Management of Persistent Pain in Older Persons. JAGS; 50 (6 Suppl): S. S206-S224.
Chibnall, J.T., Tait, R.C. et al. (2005). Effect of acetaminophen on behavior, well-being, and psychotropic medication use in nursing home residents with moderate-to-severe dementia. J Am Geriatr Soc; 53 (11): S. 1921-1929.

AMDA_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).

Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?

Seite: 7

Zitat (in Originalsprache):
“Because almost all patients in the LTC setting have predisposing factors for the development of chronic, noncancer pain, a high index of suspicion for the presence of pain is warranted. Every patient should be regularly and systematically evaluated for pain.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Ggf. weitere Bemerkungen: Screening wird nicht benannt, aber der Begriff „RECOGNITION“ wird benutzt. Im Verlauf des Schmerzassessment wird ein gestuftes Vorgehen beschrieben, wobei „RECOGNITION“ der erste „step“ gewidmet ist.

AMDA_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).

Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?

Seite: 9

Zitat (in Originalsprache):
“TABLE 3.
Nonspecific Signs and Symptoms That May Suggest the Presence of Pain
•Bracing, guarding, rubbing
• Change in behavior
•Change in gait
• Decreased activity levels
•Eating or sleeping poorly
•Fidgeting, increasing or recurring restlessness
•Frowning, grimacing, fearful facial expressions, grinding of teeth
• lass of function
•Resisting certain movements during care
• Sighing, grooning, crying, breathing heavily
• Striking out, increasing Of recurring agitation
Sources: Hurley et al, 1992; Horgas and Miller, 2008 ; Herr et al., 2006 ; Ingrid and Marsella, 2008”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[22.] Hurley, A.C., Volicer, B.J., Hanrahan, P.A. et al. (1992). Assessment of discomfort in advanced Alzheimer patients. Res Nurs Health; 15: S. 369-377.
[23.] Horgas, A., Miller, L. (2008). Pain assessment in people with dementia. Am J Nurs; 108: S. 62-70.
[24.] Herr K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older ·adults with dementia: a state-of-the-science review. J Pain Symptom Manage; 31: S. 170-192. .
[25.] Ingrid, B., Marsella, A. (2008). Factors influencing exercise participation by clients in long-term care. Perspectives; 32: S. 5-11.

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?

Seite: 19

Zitat (in Originalsprache):
"For older adults with cognitive impairment unable to report pain, assess for the presence of factors that cause pain. Whenever an older adult with cognitive impairment shows a change in mental status, pain should be considered a potential etiology. Potential sources of pain include distended bladder, incision, infection, inflammation, fracture, positioning, UTI, and constipation. Treat the underlying cause of pain using etiology specific interventions."

Evidence-Grad: siehe Referenzen III-a – IV-b
Empfehlungsstärke: B

Referenzen:
Closs, S.J., Briggs, M. (2002). Patients' verbal descriptions of pain and discomfort following orthopaedic surgery. International Journal of Nursing Studies; 39 (5): S. 563-572. (III-a).
Kovach, C.R., Weissman, D.E., Griffie, J., Matson, S., Muchka, S. (1999). Assessment and treatment of discomfort for people with late-stage dementia. Journal of Pain & Symptom Management; 18 (6): S. 412-419. (III-a).
Miller, J., Neelon, V., Dalton, J., Ng'andu, N., Bailey, D., Jr., Layman, E., Hosfeld, A. (1996). The assessment of discomfort in elderly confused patients: A preliminary study. Journal of Neuroscience Nursing; 28 (3): S: 175-182. (III-a).
Pasero, C., Reed, B.A., McCaffery, M. (1999c). Pain in the elderly. In M. McCaffery & C. Pasero (Eds.), Pain: Clinical Manual for Nursing Practice; 2nd ed.: S. 674-710. St. Louis, MO: Mosby.
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Mc Lennon_2005
Mc Lennon, M. (2005) Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing.

Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?

Seite: 5–6

Zitat (in Originalsprache):
"SCREENING CRITERIA
The following screening criteria indicate older adults who are at risk for persistent pain and are most likely to benefit from this guideline.

- Over age 65 (Centers for Disease Control [CDC] 2003; Gallagher, Verma, & Mossey, 2000. Evidence Grade = C).
- Women (Borglin, Jakobsson, Edberg, & Hallberg, 2005; Keogh, McCracken, & Eccleston, 2005; Sha et al., 2005. Evidence Grade = C).
- African Americans and Hispanics (Baker, 2005; Green, Baker, Smith, & Sato, 2003; Leveille 2004; CDC, 2005; Ruehlman, Karoly, & Newton, 2005. Evidence Grade = C).
- Nursing home residents (Chu et al., 2004; Cohen-Mansfield, 2004; Won et al., 2004. Evidence Grade = C).
- Presence of cognitive-impairment, particularly those who are non-verbal (Fries et al., 2001; Zieber et al., 2005. Evidence Grade = C).
- Presence of arthritis and musculoskeletal diseases (Leveille, 2004; Sha et al., 2005. Evidence Grade = B).
- Presence of depression (Mossey & Gallagher, 2004; Tsai et al., 2003; Unutzer, Ferrell, Lin, & Marmon, 2004. Evidence Grade = B)."

Evidence-Grad und/oder Empfehlungsstärke: B & C

Referenzen:

Baker, T.A. (2005). Chronic pain in older Black Americans: the influence of health and psychosocial factors. Ethnicity & Disease; 15: S. 179-186. (R)

Borglin, G., Jakobsson, U., Edberg, A.K., Hallberg, I.R. (2005). Self-reported health complaints and their prediction of overall health and health-related quality of life among elderly people. International Journal of Nursing Studies; 42: S. 147-158. (R)

Centers for Disease Control (2005). Racial/ethnic differences in the prevalence and impact of doctor-diagnosed arthritis – United States, 2002. Morbidity & Mortality Weekly Report; 54: S. 119-123. (L)

Centers for Disease Control (2003). Public health and aging: projected prevalence of selfreported arthritis or chronic joint symptoms among persons aged >65 years – United States, 2005-2030. Morbidity & Mortality Weekly Report; 52: S. 489-491. (L)

Fries, B.E., Simon, S.E., Morris, J.N., Flodstrom, C., Bookstein, F.L. (2001). Pain in U.S. nursing homes: validating a pain scale for the minimum data set. Gerontologist; 41: S. 173-179. (R)

Gallagher, R.M., Verma, S., Mossey, J. (2000). Chronic pain: Sources of late-life pain and risk factors for disability. Geriatrics; 55: S. 40-47. (L)

Green, C.R., Baker, T.A., Smith, E.M., Sato, Y. (2003). The effect of race in older adults presenting for chronic pain management: a comparative study of black and white Americans. The Journal of Pain; 4, 82-90. (R)

Keogh, E., McCracken, L.M., Eccleston, C. (2005). Do men and women differ in their response to interdisciplinary chronic pain management? Pain; 114: S. 37-46. (R)

Leveille, S.G. (2004). Musculoskeletal aging. Current Opinions in Rheumatology; 16: S. 114-118. (L)

Mossey, J.M., Gallagher, R.M. (2004). The longitudinal occurrence and impact of comorbid chronic pain and chronic depression over two years in continuing care retirement community residents. Pain Medicine; 5: S. 335-348. (R)

Ruehlman, L.S., Karoly, P., Newton, C. (2005). Comparing the experiential and psychosocial dimensions of chronic pain in African Americans and Caucasians: findings from a national community sample. Pain Medicine; 6: S. 49-60. (R)

Sha, M.C., Callahan, C.M., Counsel, S.R., Westmoreland, G.R., Stump, T.E., Kroenke, K. (2005). Physical symptoms as a predictor of health care use and mortality among older adults. The American Journal of Medicine; 118: S. 301-306. (R)

Tsai, P.F., Tak, S., Moore, C., Palencia, I. (2003). Testing a theory of chronic pain. Journal of Advanced Nursing; 43: S. 158-169. (R)

Unutzer, J, Ferrell, B., Lin, E. H., Marmon, T. (2004). Pharmacotherapy of pain in depressed older adults. Journal of the American Geriatrics Society; 52: S. 1916-1922. (R)

Zieber, C.G., Hagen, B., Armstrong-Esther, C., Aho, M. (2005). Pain and agitation in longterm care residents with dementia: use of the Pittsburgh Agitation Scale. International Journal of Palliative Nursing; 11: S. 71-78. (R)

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 7: Welche Vortest-Wahrscheinlichkeit spricht für ein Screening?
Seite: 93
Zitat (in Originalsprache): „Proactieve screening (van kwetsbaarheid en pijn) is een optie, hoewel er geen evidence bestaat over het uiteindelijke resultaat hiervan. Door de gezondheidsraad wordt vooralsnog vroegsignalering bij mensen boven 75 jaar aanbevolen (Gezondheidsraad, 2009).“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Gezondheidsraad (2009). Preventie bij ouderen: focus op zelfredzaamheid. Den Haag: Gezondheidsraad. publicatienr 2009/07

Frage 8: Wie sollte nach Schmerzen gescreent werden?

AGS 2002 AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 208
Zitat (in Originalsprache): “Initial evaluation of present pain complaint should include pain characteristics, such as intensity, character, frequency (or pattern, or both), location, duration, and precipitating and relieving factors.”
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 208
Zitat (in Originalsprache): “Initial evaluation should include a description of pain in relation to impairments in physical and social function (e.g., acitivities of daily living (ADLs), instrumental activities of daily living (IADLs), sleep, appetite, energy, exercise, mood, cognitive function, interpersonal and intimacy issues, social and leisure activities, and overall quality of life).”
Evidence-Grad: II Empfehlungsstärke: A
Referenzen: [26.] Ferrell, B.A. (2000). Pain. In: Osterweil, D., Brummel-Smith, K., Beck, J.C., (ed.) Comprehensive. Geriatric Assessment. New York: McGraw Hill: S. 381- 397. [27.] Helme, R.D., Katz, B., Gibson, S.J. et al. (1996). Multidisciplinary pain clinics for older people. Do they have a role? Clin Gertiatr Med; 12: 563-582. [28.] Max, M.B., Payne, R., Edwards, W.T. et al. (1999). Principles of Analgesis Drug Use in the Treatment of acute Pain and Cancer pain. 4 th edition, Glenville II: American Pain Society. [29.] Ferrell, B.A., Ferrell, B.R., Rivera, L. (1995). Pain in cognitively impaired nursing home patients. J Pain Symptom Manage; 10: S. 591-598. [30.] Parmelee, P.A. (1996). Pain in cognitively impaired older persons. Clin Geriatr Med; 12: S. 473–487. [31.] Herr, K.A., Mobily, P.R., Kohout, F.J., Wagenaar, D. (1998). Evaluation of the Faces Pain Scale for use with the elderly. Clinical Journal of Pain; 14: S. 29-38. [32.] Feldt, K.S., Warner, M.A., Ryden, M.B. (1998b). Examining pain in aggressive cognitively impaired older adults. Journal of Gerontological Nursing; 24 (11): S. 14-22.. [33.] Weiner, D., Peterson, B., Keefe, F. (1998). Evaluating persistent pain in long term care residents: What role for pain maps? Pain; 76 (1-2): S. 249-257. [34.] Wynne, C.F., Ling, S.M., Remsburg, R. (2000). Comparison of pain assessment instruments in cognitively intact and cognitively impaired nursing home residents. Geriatric Nursing; 21 (1): S. 20-23. [35.] Briggs, M., Closs, J. (1999). A descriptive study of the use of visual analogue scales and verbal rating scales for the assessment of postoperative pain in orthopedic patients. Journal of Pain and Symptom Management; 18 (6): S. 438-446. [36.] Gloth, F.M. III., Scheve, A.A., Stober, B.S. et al. (2001). The Functional Pain Scale: reliability, validity and responsiveness in an elderly population. J Am Med Dir Assoc; 2: S. 110-114. [37.] Ferrell, B.A., Ferrell, B.R., Osterweil, D. (1990). Pain in the nursing home. J Am Geriatr Soc.; 38: S. 409–414.

[38.] Grossberg, G.T., Sherman, L.K., Fine, P.G. (2000). Pain and behavioral disturbances in the cognitively impaired older adult: assessment and treatment issues. Ann Long Term Care; 8: S. 22-24.
[39.] Parmelee, P.A. (1994). Assessment of pain in the elderly. In Lawtoon, M.P., Teresi, J. (ed.). Annual Review of Gerontology and Geriatrics. New York: Springer Publishing Company: S. 281-301.
[40.] Duggleby, W., Lander, J. (1994). Cognitive status and postoperative pain: Older adults. Journal of Pain & Symptom Management; 9 (1): S: 19-27.
[41.] Miller, J., Neelon, V., Dalton, J., Ng'andu, N., Bailey, D., Jr., Layman, E., Hosfeld, A. (1996). The assessment of discomfort in elderly confused patients: A preliminary study. Journal of Neuroscience Nursing; 28 (3): S. 175-182.
[42.] Gagliese, L., Melzack, R. (1997). Age differences in the quality of chronic pain: a preliminary study. Pain Res Manage; 2: S. 157-162.

AGS 2002
AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.

Frage 8: Wie sollte nach Schmerzen gescreent werden?

Seite: 208

Zitat (in Originalsprache):
“Initial assessment should include observation of physical functioning (e.g., measures of ADLs, burning, discomfort, aching, soreness, heaviness, tightness).”

Evidence-Grad: III
Empfehlungsstärke: B

Referenzen:
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[32.] Feldt, K.S., Warner, M.A., Ryden, M.B. (1998b). Examining pain in aggressive cognitively impaired older adults. Journal of Gerontological Nursing; 24 (11): S. 14-22.
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Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 210
Zitat (in Originalsprache): “A variety of terms synonymous with pain should beused to screen older patients (e.g., burning, discomfort, aching, soreness, heaviness, tightness).”
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 210
Zitat (in Originalsprache): “D. Initial assessment should include evaluation of psychologic function, including mood (e.g., depression, anxiety), self-efficacy, pain coping skills, helplessness, and pain-related fears. (IIA) E. Initial assessment should include evaluation of social support, caregivers, family relationships, work history, cultural environment, spirituality, and healthcare accessibility. (IIB)”
Evidence-Grad: II & II Empfehlungsstärke: A&B
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 8
Zitat (in Originalsprache): “The best indicator of the pain experience is the patient' s own report, which must include an assessment of pain intensity and the effect of pain on activities of daily living.[2] Asking the patient about pain directly rather than relying on the patient to volunteer the information improves the detection of pain.[16] It is helpful to ask the question in different ways, such as • "Are you feeling any aching or soreness now?” • "Do you hurt anywhere?" • "Are you having any discomfort?" • "Have you taken any medications for pain?" • "Have you had any aching or soreness that kept you up at night?" • "Have you had trouble with any of your usual day-to-day activities?"

• “How intense is your pain?"
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [2.] American Geriatries Society (AGS) (2009). Panel on the Pharmaeologieal Management of Persistent Pain in Older Persons. Pharmaeological management of persistent pain in older persons. J Am Geriatr Soe; 57: S. 1331-1346. [16.] CMS. Minimum Data Set, Version 3.0 (MDS 3.0). Baltimore, MD: Centers for Medicare and Medicaid Services. Available at: https:/ / www.cms.gov/nursinghomequalityinits/. Accessed 12/2/11.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 7
Zitat (in Originalsprache): “Screening/Care planning Evidence based statement Self reporting of pain is the gold standard method for identifying pain. Pain has been referred to as ‘The Fifth Vital Sign™’. This emphasises the importance of considering, measuring and monitoring the presence of pain systematically. It is important to encourage all health care workers to include a routine screening question to assess for the presence of pain in assessments of older people. In the context of the single assessment process proposed in the National Service Framework for Older People[18] this would include the overview assessments as well as more detailed levels of assessment. Recommendation Any health assessment of older people should include asking whether they experience pain The single assessment process should include a question seeking to identify the presence of pain”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [18.] Department of Health (2001). National Service Framework: Older People Crown Copyright.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 7-8
Zitat (in Originalsprache): “Evidence based statements Enquiring about pain when assessing the health of older people is the most effective way of determining the presence of pain. Older people may use a wide range of words to express pain e.g. sore, hurting, aching In addition to asking a person about pain, the use of an intensity rating scale will enhance the detection of pain Every effort should be made to facilitate communication particularly with those people with sensory impairments (use of e. g. hearing aids) Attention to pain within the history is the most effective way of determining the presence of pain[19, 20]. The history should be supplemented by the use of an intensity rating scale to enhance the identification of pain (Appendix 2) and to assess the response to analgesics[21, 22, 23]. Patients’ own words are important in documenting the experience of pain[24]. Some patients who respond “no” when asked if they have pain will respond affirmatively to follow-up questions using words such as, aching and soreness[19]. Older

people may use a wide range of words to express pain[24, 25].
Older people select fewer words from standardized instruments than younger people to describe their pain[26] and use additional words, phrases, similes and word repetition not found in self-report instruments.[24, 27]
Role of intensity scales as a supplement to detecting pain
Some older people may be more willing to score pain on a pain intensity rating scale than say they have pain[21]. Intensity rating scales can enhance the detection of pain in nursing home residents.[22, 23, 30]
Recommendations
Any health assessment of an older person, including the single assessment process, should include asking whether he/she experiences pain (using terms such as pain, ache, hurt)
The assessment should recognise that older people use a wide range of words to describe pain.
The assessment should recognise that older people may be reluctant to acknowledge and report pain."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[19.] Weiner, D.K., Peterson, B., Ladd, K., McConnell, E.R.N., Keefe, F. (1999). Pain in nursing home residents: An exploration of prevalence, staff perspectives and practical aspects of measurement. Clinical Journal of Pain, 15 (2): S. 92-101.

[20.] Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2001). Assessing pain and pain relief in geriatric patients with non-Pathological fractures with different rating scales. Aging Clinical Experimental Research; 13: S. 355-361.

[21.] Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patients. Aging Clin Exp Res; 12: S. 380-387.

[22.] Kamel, H.K., Phlavan, M., Malekgoudarzi, B., Gogal, P., Morley, J.E. (2001). Utilizing pain assessment scales increases the frequency of diagnosing pain among elderly nursing home residents. J Pain Symptom Management; 21: S. 450-455.

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[24.] Duggleby, W. (2002). The language of pain at the end of life. Pain Management Nursing; 3 (4): S. 154-160.

[25.] Closs, S.J., Briggs, M. (2002). Patients' verbal descriptions of pain and discomfort following orthopaedic surgery. International Journal of Nursing Studies; 39: S. 563-572.

[26.] Gagliese, L., Melzack, R. (2003). Age-related differences in the qualities but not the intensity of persistent pain. Pain; 104: S. 597-608.

[27.] Schofield, P.A. (2006). Talking to older people in care homes: Perceptions of their pain and their preferred management strategies. Results of a pilot study. International Journal of Disability & Human Development: 5 (1): S. 53-59.

[30.] Closs, S.J., Barr, B., Briggs, M., Cash, K., Seers, K. (2004). A comparison of five pain assessment scales for nursing home residents with varying degrees of cognitive impairment. Journal of Pain & Symptom Management; 27 (3): S. 196-205.

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 8: Wie sollte nach Schmerzen gescreent werden?

Seite: 9-11

Zitat (in Originalsprache):
"Evidence based statements
Autonomic signs are often present during severe acute pain, but not in chronic pain, regardless of severity
Facial expressions can indicate the presence of pain in older people with and without

cognitive impairment.
Guarding of body movements can indicate the presence of pain in older people with and without cognitive impairment.
Verbalisations or vocalisations including sighing, grunting, groaning, calling out, can indicate pain.
Changes in interpersonal interactions e.g. aggression, withdrawal, resisting care can indicate pain.
Mental status changes e.g. confusion, crying, distress, irritability can indicate pain
Estimation of pain intensity from observation of facial expressions or behaviour is not reliable in older people with and without cognitive impairment
Observing patients during physical activity can help identify pain
Observation is an important component of assessing pain. While reliance should not be placed on observation alone it provides important information regarding pain. Observation is particularly important for patients who have difficulty in communicating [31]. Observation may include positive reactions such as facial expressions, physical reactions, behavioural characteristics and negative reactions such as avoiding functional and recreational activities. Observation during movement enhances the detection of some pains particularly musculoskeletal pain.[32, 33]
Behaviours potentially indicating the presence of pain vary enormously from individual to individual and also vary in the same individual [34]. Some patients may show subtle changes e.g. becoming withdrawn and others becoming aggressive and verbalising and vocalising their pain. It should be remembered that such behaviours may have causes other than pain. All types of unusual behaviour should therefore be comprehensively monitored and their causes considered, especially during patient activity such as walking, transfers or during procedures. The identification of behavioural indicators of possible pain should prompt a more detailed clinical assessment[35].
In addition, physiological changes should prompt a search for possible pain. Physiological cues to the possible presence of acute pain include autonomic responses, commonly pallor, sweating, tachypnoea/altered breathing pattern, tachycardia and hypertension. With persistent or chronic pain states autonomic signs rarely occur and the absence of such signs does not mean the absence of chronic pain [31].
Facial expressions:
Grimacing has been shown to increase during activity, especially in those with cognitive impairment. Several facial actions characteristic of pain have been identified including brow raising, brow lowering, cheek raising, eyelids tightening, nose wrinkling, lip corner pulling, chin raising, and lip puckering etc [36, 37].

Facial expression without pain Facial expression with pain
Reproduced with permission from Pain in Residential Aged Care Facilities: Management Strategies. The Australian Pain Society August 2005 [38].
Body movements:
In older people guarding and to a lesser extent bracing can be used to detect movement-exacerbated pain [32, 33].

- Guarding refers to an abnormally stiff, rigid or interrupted movement while changing position.
- Bracing refers to a stationary position in which a fully extended limb maintains and supports an abnormal weight distribution held for at least 3 seconds [39].

Increased guarding has been observed during transfers and walking compared with sitting, standing and reclining. Non-verbal measures were related, but did not predict each other or self-report, suggesting they tap into different domains of pain [33].

Changes in behaviour.
Changes in behaviour may commonly be related to underlying but unexpressed pain. Behaviour changes may include aggression and withdrawal, and are particularly important in cognitively impaired patients with severe communication problems who may be reticent or unable to report pain problems. Different patients have different pain behaviours e.g clutching the painful area, sighing, moaning, screaming, pacing [34]. Individual assessment is needed.

Recommendations
In people with difficulty in communicating including cognitive impairment and in situations where procedures might cause pain, an observational assessment is additionally required.
Observations should include facial expressions, body movements, verbalisations, vocalisations, physiology and changes in interpersonal interactions, changes in activity levels and patterns and changes in mental status or affect.
Pain behaviours are very individual and clinical judgement and familiarity with the older person is important in interpreting behaviour."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[31.] Kunz, M., Mylius, V., Schepelmann, K., Hemmeter, U., Lautenbacher, S. (2006). Pain Processing in Demented Patients as Indicated by Subjective, Facial, Reflexive and Autonomic Pain Responses. Journal of Psychophysiology; 20 (2): S. 127.
[32.] Weiner, D., Pieper, C., Mc Connell, E., Martinez, S., Keefe, F. (1996). Pain measurement in elders with chronic low back pain : traditional and alternative approaches. Pain; 67: S. 461-467.
[33.] Hadjistavropoulos, T., LaChapelle, D.L., MacLeod, F.K. et al. (2000). Measuring movement- Exacerbated pain in cognitively impaired frail elders. The Clinical Journal of Pain; 16: S. 54-63.
[34.] Weiner, D., Peterson, B., Keefe, F. (1999). Persistent pain-associated behaviours in the nursing home: resident versus caregiver perceptions. Pain; 80: S. 577-588.
[35.] Herr, K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: a state of the science review. Journal of Pain Symptom Management; 31 (2): S. 170-192.
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[37.] Hadjistavropoulos, T., La Chapelle, D.L., Hadjistavropoulos, H.D., Green, S., Asmundson, G.J.G. (2002). Using facial expressions to assess musculoskeletal pain in older persons. Eur J Pain; 6: S. 179-187.
[38.] The Australian Pain Society (2005). Pain in residential aged care facilities: management strategies. The Australian Pain Society.
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Hadjistavropoulos et al._2010
Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.

Frage 8: Wie sollte nach Schmerzen gescreent werden?

Seite: 107 &110

Zitat (in Originalsprache):
"Always attempt self-report regardless of level of cognitive functioning.
(...) highlighted the importance of assessing pain during movement-based tasks and not simply when the older adult is at rest."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin

J Pain; 23: S. S1–S43.
AGS Panel on Persistent Pain in Older Persons (2002). Clinical practice guidelines: the management of persistent pain in older persons. J Am Geriatr Soc.; 50: S. S205–S224.
Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs.;7:44–52.doi:10.1016/j.pmn.2006.02.003

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., K. Herr, et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain; 23 (1): S1-S43.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: S3
Zitat (in Originalsprache): "A comprehensive evaluation is required when the source of pain complaints or behaviors is not obvious and when treatment impacts coexisting conditions. This assessment should include a screen for comorbid conditions likely to affect management."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., K. Herr, et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain; 23 (1): S1-43.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: S14
Zitat (in Originalsprache): "It is often useful to elicit information about the presence of pain with simple questions, such as ''do you have any pain or discomfort today? What about aching or soreness?' [106,109]"
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [106.] Weiner, D., Peterson, B., Ladd, K. et al. (1999). Pain in nursing home residents: an exploration of prevalence, staff perspectives, and practical aspects of measurement. Clin J Pain; 15: S. 92–101. [109.] Closs, S.J., Briggs, M. (2002). Patients' verbal descriptions of pain and discomfort following orthopaedic surgery. Int J Nurs Stud; 39: S. 563–572.

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 5
Zitat (in Originalsprache): "If the resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal resident. Additionally, the facility shall seek information from the resident's family, caregiver or other representative, if available and known to the facility."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 12
Zitat (in Originalsprache):

“Complete an initial, rapid pain assessment for patients presenting in acute pain of moderate to severe intensity or who appear to be in significant distress including the following: 2 Level of consciousness (LOC) including orientation to person/self, time and location. 3 Characteristics of the pain, including: • Intensity of pain (see section for recommendations regarding tools) • Location • Duration of pain (onset and pattern) • Quality 2 Changes in vital signs, including: • Respiratory status • Heart Rate • Blood pressure • Temperature Absence of these autonomic responses does NOT mean absence of pain. (AGS, 2002; APS, 2003; Kehlet, 1989; Pasero et al., 1999c; VHA/DoD, 2002).—D “
Evidence-Grad: siehe Referenzen: IV & V-b Empfehlungsstärke: D
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. APS (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (5th ed.). Glenview, Illinois: American Pain Society (APS). (V-b). Kehlet, H.M. (1989). Surgical Stress: The role of pain and analgesia. British Journal of Anaesthesia; 63: S. 189-195. (IV). Pasero, C., Reed, B.A., McCaffery, M. (1999c). Pain in the elderly. In M. McCaffery, C. Pasero (ed.), Pain: Clinical Manual for Nursing Practice; 2nd ed.: S. 674-710. St. Louis, MO: Mosby. (V-a). VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing.
Frage 8: Wie sollte nach Schmerzen gescreent werden?
Seite: 6–7
Zitat (in Originalsprache): 2 “ Ask about pain presence The initial step in assessing for persistent pain is to ask about the presence of pain. If pain presence is confirmed, then the nurse should further assess for criteria associated with the definition of persistent pain provided by Bonica (1990), that of lasting 1 month longer than expected, or associated with a chronic constant pain producing condition, or characterized by recurrent intervals over time. In addition, obtain information about the intensity and location of pain as well as any precipitating and relieving factors. The BPI contains a body map for indicating pain location (s), and an area for indicating treatments and medications, as well as factors that relieve the pain. Some older adults may identify with words other than pain, such as discomfort, hurt, or ache (AGS, 2002). When using this guideline, the nurse should consistently use the same word throughout the process.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. 1-20. (N) Bonica, J. (ed.) (1990). Management of pain. 2nd ed.: S. 552-559. Philadelphia: Lee &

Feibiger. (L)

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 8: Wie sollte nach Schmerzen gescreent werden?

Seite: 10 & 38

Zitat (in Originalsprache)
"(…) by asking the person or family/care provider about the presence of pain, ache or discomfort.
Self-report is the primary source of assessment for verbal, cognitively intact persons.
Family/care provider reports of pain are included for children and adults unable to give self-report."

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke:C

Referenzen:
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
Cavender, K., Goff, M.D., Hollon, E.C., Guzzetta, C.E. (2004). Parents' positioning and distracting children during venipuncture: Effects on children's pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56.
Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research; 35 (4): S. 58-71.
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
Malviya, S., Voepel-Lewis, T., Burke, C., Merkel, S., Tait, A.R. (2006). The revised FLACC observational pain tool: Improved reliability and validity for pain assessment in children with cognitive impairment. Paediatric Anaesthesia; 16 (3): S. 258-265.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage Nr 8: Wie sollte nach Schmerzen gescreent werden?

Seite: 14 (Teil II)

Zitat (in Originalsprache):
"Miaskowski (2000) adviseert medewerkers in de zorg dan ook om in te spelen op attitudes van ouderen over pijn:
– de gedachte bij ouderen dat pijn een normaal onderdeel is van veroudering, blijkt versterkt te kunnen worden door bepaalde opmerkingen van medewerkers in de gezondheidszorg;
– vermijd deze opmerkingen en neem de pijnklachten van elke patiënt serieus (ongeacht de leeftijd). Begrip tonen, geruststellen en eventueel psycho-educatie kunnen verdere misvattingen voorkomen;

– wees pro-actief en vraag alle ouderen of ze pijn ervaren. Vraag dit ook routinematig. Dit nodigt uit tot een open communicatie;
– verzeker ouderen ervan, dat pijn niet altijd indicatief is voor een ernstige ziekte en dat zorgvuldige diagnostiek nodig is voor vroege detectie en adequate behandeling van de onderliggende oorzaak van pijn;
– gebruik verschillende woorden om pijn te beschrijven en noteer de woorden die individuele ouderen gebruiken als specifieke termen voor pijn;
– gesprekken dienen te verlopen in ontspannen sfeer en voor het uitvragen van de pijngeschiedenis zijn wellicht meerdere gesprekken nodig; (...)."

"Recommendation:
Aanbevelingen
3d Als onderdeel van de dagelijkse zorg en in het contact met een kwetsbare oudere zonder of met milde tot matige cognitieve/communicatieve beperkingen dient gevraagd te worden of men pijn ervaart (met behulp van termen zoals 'pijn', 'zeer', 'gevoelig')."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Miaskowski, C. (2000). The impact of age on a patiënt's perception of pain and ways it can be managed. Pain Manag Nurs; 1 (3) (Supplement 1): S. 2-7.

Frage 9: Welchen Zeitraum (aktuell und / oder zurückliegend) sollte das Screening erfassen?

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 9: Welchen Zeitraum (aktuell und / oder zurückliegend) sollte das Screening erfassen?
Seite: 8
Zitat (in Originalsprache): “It is also often helpful to ask family members how the patient historically has expressed pain or discomfort.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing.
Frage 9: Welchen Zeitraum (aktuell und / oder zurückliegend) sollte das Screening erfassen?
Seite: 6–7
Zitat (in Originalsprache): 3 Ask about pain presence “The initial step in assessing for persistent pain is to ask about the presence of pain. If pain presence is confirmed, then the nurse should further assess for criteria associated with the definition of persistent pain provided by Bonica (1990), that of lasting 1 month longer than expected, or associated with a chronic constant pain producing condition, or characterized by recurrent intervals over time”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. 1-20. (N) Bonica, J. (ed.) (1990). Management of pain. 2nd ed.: S. 552-559. Philadelphia: Lee & Feibiger. (L)

Frage 10: Wann sollte nach Schmerzen gescreent werden?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. S205-S224.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 208
Zitat (in Originalsprache): “On initial presentation or admission of any older person to any healthcare service, a healthcare professional should assess the patient for evidence of persistent pain. (IIB)”
Evidence-Grad: II Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

APS_2005 APS (2005). Pain in Residential Aged Care Facilities – Management Strategies.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 2
Zitat (in Originalsprache): “ASKING COMMUNICATIVE RESIDENTS ABOUT THEIR PAIN Staff taking a general medical history or pain history should sit down with the resident, make eye contact and demonstrate a willingness to discuss whether the resident has any pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: American Geriatrics Society Panel Guidelines on Persistent Pain in Older Persons (2002). J Am Geriatr Soc; 50: S. S205-S224.

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 4 (Kurzversion)
Zitat (in Originalsprache): “Is pain present? Evaluate the patient for pain upon admission, during periodic scheduled assessments, and whenever a change occurs in his or her condition (e.g., after a fall or other trauma; when a change occurs in the patient's behavior, daily routines, or mental status). l Change in gait l Loss of function l Decreased activity levels l Resisting certain movements during care l Bracing, guarding, rubbing l Fidgeting, increasing or recurring restlessness l Frowning, grimacing, fearful facial expressions, grinding of teeth l Change in behavior l Striking out, increasing or recurring agitation l Eating or sleeping poorly l Sighing, groaning, crying, breathing heavily “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 8
Zitat (in Originalsprache): “Every patient should be regularly and systematically evaluated for pain. The process described in the following steps should be conducted, a minimum, at the following times: • Upon a patient's admission to a LTC facility and at each quarterly and annual review; • Whenever a patient has an acute illness or injury or experiences a decline in function or a change in mood or cognition; • Whenever a patient exhibits unexpected social withdrawal or signs of depression; • Whenever vital signs are obtained (i.e., as the "fifth vital sign"); • At least daily, for patients with a known painful condition; and • Before and after administration of as-needed (PRN) analgesic medication.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 8
Zitat (in Originalsprache): “Any health assessment of an older person, including the single assessment process, should include asking whether he/she experiences pain (using terms such as pain, ache, hurt).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 7
Zitat (in Originalsprache): “Enquiring about pain when assessing the health of older people is the most effective way of determining the presence of pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 107
Zitat (in Originalsprache): “Baseline scores should be collected for each individual (ideally on a regular basis which would allow for the examination of unusual changes from the persons typical pattern of scores).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for

assessing pain in older persons with dementia residing in long-term care facilities.

Frage 10: Wann sollte nach Schmerzen gescreent werden?

Seite: 110

Zitat (in Originalsprache):
"(…) it is recommended that older adults in long-term care be assessed for pain within 24 hours of admission (…)."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S. et al. (2009). Transforming long-term care pain management in North America: The policy-clinical interface. Pain Med.; 10: S. 506–20. doi:10.1111/j.1526-4637.2009.00566.x

Hadjistavropoulos et al._2007
Hadjistavropoulos, T., K. Herr, et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain; 23 (1): S. S1-S43.

Frage 10: Wann sollte nach Schmerzen gescreent werden?

Seite: S13

Zitat (in Originalsprache):
"Assessment of ''Red Flag'' Conditions
There are several pain-associated clinical conditions that are common in older persons to which the clinician must always be alert when examining a patient because delay in diagnosis may lead to considerable excess morbidity. These red flag conditions include the following:
Orthopedic injuries associated with a witnessed or unwitnessed fall. This may present in the form of a recent behavioral change in an older patient with limited self-reporting capability. Such a presentation should trigger a physical examination for underlying injury. Similarly, spontaneous fractures (including vertebral collapse) due to osteopenia that may result in neural compression pain syndromes need to be considered in this population. Temporal arteritis[99] is a cause of new onset headache in older people and if untreated may cause irreversible blindness. The characteristic finding on examination is a tender, nonpulsatile, firm temporal (and occasionally occipital) artery, although very often this finding is absent. A history of jaw claudication and sudden onset hip girdle or shoulder girdle prolonged morning stiffness (ie, concomitant symptoms of polymyalgia rheumatica) should raise suspicion of temporal arteritis.
Bone pain that is new or worse at night (or anytime the patient is lying down) and is not associated with acute injury should raise the possibility of metastatic disease[100].
The examination for evoked pain on palpitation must be careful but firm. A low threshold should exist for radiologic confirmation to detect and prevent pathologic fractures.
Vascular compromise due to occlusion, embolus, thrombosis, or aneurysm. Ischemic limbs are generally cool, pale, and may be mottled or appear cyanotic. Pulses are diminished or not palpable and capillary return to gentle skin compression is delayed. A long-standing sensory neuropathy can often be detected, or there may be acute sensory and/or motor disturbance. Hyperalgesia, hyperpathia, and allodynia may be found in some cases."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
99. Spiera, R., Spiera, H. (2004). Inflammatory diseases in older adults: cranial arthritis. Geriatrics; 59: S. 25–29.
100. Berger, A.M., Koprowski, C. (2002). Bone pain: assessment and management. In: Berger, A.M., Portenoy, R.K., Weissman, D.E. (ed.). Principles and Practice of Palliative Care & Supportive Oncology. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins: S. 53–67.

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 5
Zitat (in Originalsprache): “A Pain Screen, (…), shall be conducted upon admission. A Pain Rating Scale shall be completed and documented, at a minimum, in the following circumstances: 1. as part of the Pain Screening upon admission 2. upon re-admission 3. upon day of planned discharge (send a copy with the resident) 4. when warranted by changes in the resident’s condition or treatment plan 5. self reporting of pain and/or evidence of behavioral cues indicative of the presence of pain 6. to identify and monitor the level of pain and/or the effectiveness of treatment modalities until the resident achieves consistent pain relief or pain control.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 9
Zitat (in Originalsprache): “A comprehensive pain assessment should be completed prior to a known painful event, such as surgery or diagnostic procedures. (See Pain Assessment and Management Plan.)”
Evidence-Grad: siehe Referenzen III-a – III-b Empfehlungsstärke: nicht ausgewiesen
Referenzen: Jensen, M.P., Smith, D.G., Ehde, D.M., Robinsin, L.R. (2001). Pain site and the effects of amputation pain: further clarification of the meaning of mild, moderate, and severe pain. Pain; 91 (3): S. 317-322. (III-a). Mendoza, T.R., Chen, C., Brugger, A., Hubbard, R., Snabes, M., Palmer, S.N., Zhang, Q., Cleeland, C.S. (2004a). Lessons learned from a multiple-dose post-operative analgesic trial. Pain; 109 (1-2): S. 103-109. (III-b). Paul, S.M., Zelman, D.C., Smith, M., Miaskowski, C. (2005). Categorizing the severity of cancer pain: further exploration of the establishment of cutpoints. Pain; 113 (1-2): S. 37-44. (III-a). Serlin, R.C., Mendoza, T.R., Nakamura, Y., Edwards, K.R., Cleeland, C.S. (1995). When is cancer pain mild, moderate or severe? Grading pain severity by its interference with function. Pain; 61 (2): S. 277-284. (III-b). Zelman, D.C., Dukes, E., Brandenburg, N., Bostrom, A., Gore, M. (2005). Identification of cutpoints for mild, moderate and severe pain due to diabetic peripheral neuropathy. Pain; 115 (1-2): S. 29-36. (III-a).

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS. RCP_2007 & Royal College of Physicians, British Geriatric Society et al. (2007). The Assessment of Pain in Older People: National Guidelines. Concise guidance to good practice series No 8. London, Royal College of Physicians.)
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 5 (RCP_2007)
Zitat (in Originalsprache): “Any health assessment should include enquiry about pain, using a range of alternative descriptors (eg sore, hurting, aching).”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: Empfehlungsgrad C
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 3 (Version 2007)
Zitat (in Originalsprache): “1. Screen all persons at risk for pain at least once a day (when undertaking other routine assessments), by asking the person or family/care provider about the presence of pain, ache or discomfort. In situations where the individual is non-verbal, use behavioural indicators to identify the presence of pain.”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: Grade of Recommendation: C
Referenzen: American Pain Society (APS) (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS). Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39. Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90. Cavender, K., Goff, M.D., Hollon, E.C., Guzzetta, C.E. (2004). Parents’ positioning and distracting children during venipuncture: Effects on children’s pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56. Davis, M., Walsh, D. (2004). Cancer pain: How to measure the fifth vital sign. Cleveland Clinic Journal of Medicine; 71 (8): S. 625-632. Institute for Clinical Systems Improvement (ICSI) (2006). Assessment and management of acute pain. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI). Malviya, S., Voepel-Lewis, T., Burke, C., Merkel, S., Tait, A.R. (2006). The revised FLACC observational pain tool: Improved reliability and validity for pain assessment in children with cognitive impairment. Paediatric Anaesthesia; 16 (3): S. 258-265. van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609. van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491. Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 10 & 38
Zitat (in Originalsprache): "(...) states he/she has pain; experiences change in condition; diagnosed with chronic painful disease; has history of chronic unexpressed pain; taking pain-related medication for >72 hours; has distress related behaviours or facial grimace; indicates that pain is present through family/staff/volunteer observation. Any older person reporting to a health care facility should be routinely screened for the presence of pain."
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: American Geriatric Society Panel on Chronic Pain in Older Persons (1998). The manangement of chronic pain in older persons J Am Ger Soc; 46 (5): S. 635-651.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 32
Zitat (in Originalsprache): "Zoals ook in hoofdstuk 2 benoemd is observatie een bruikbaar aanvullend onderdeel van de beoordeling van pijn. De samenhang tussen geobserveerd pijngedrag en zelfgerapporteerde pijn is bij ouderen met chronische pijn het sterkst **tijdens dagelijkse activiteiten** (sterker dan tijdens zitten, lopen of staan). Tijdens dagelijkse activiteiten, zoals sokken aandoen en opstaan uit bed, worden meer verschillende pijngedragingen geobserveerd en ook meer frequent (Labus et al, 2003; Herr et al, 2006). Sommige pijngedragingen zijn moeilijk herkenbaar, zoals agitatie/irritatie, onrust, verwarring of verandering in eetlust. Fysiologische veranderingen (hartslag, bloeddruk, ademhaling) zijn niet gevoelig genoeg om pijn te onderscheiden van andere vormen van ongemak/onrust."
Evidence-Grad: und / oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Labus, J.S., Keefe, F.J., Jensen, M.P. (2003). Self-reports of pain intensity and direct observations of pain behavior: when are they correlated? Pain; 102: S. 109-124. Herr, K., Bjøro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: a state of the science review. Journal of Pain and Symptom Management; 31 (2): S. 170-192.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 10: Wann sollte nach Schmerzen gescreent werden?
Seite: 100
Zitat (in Originalsprache): "Structuurindicatoren 1. Binnen de instelling wordt bij elke kwetsbare oudere tijdens de dagelijkse zorg nagegaan of deze last heeft van pijn (ja/nee)."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 11: Wie oft sollte ein Screening stattfinden?

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 11: Wie oft sollte ein Screening stattfinden?
Seite: 8
Zitat (in Originalsprache): "• Upon a patient's admission to a LTC facility and at each quarterly and annual review; • Whenever a patient has an acute illness or injury or experiences a decline in function or a change in mood or cognition; • Whenever a patient exhibits unexpected social withdrawal or signs of depression; • Whenever vital signs are obtained (i.e., as the "fifth vital sign"); • At least daily, for patients with a known painful condition; and • Before and after administration of as-needed (PRN) analgesic medication."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 11: Wie oft sollte ein Screening stattfinden?
Seite: 8
Zitat (in Originalsprache): "Step 1 Is pain present? Evaluate the patiet for paon upon admission, during geriodic scheduled assessments, and whenever a change accouirs in his or her condition (e.g., alfter a fall or oter trauma or when a change ociurs ion the patients`s behavior, daily routines, or mental status. The best indicator of the pain experience is the patients`s own report, which must include an assessment of pain intensity and the effect of pain on activities of daily living.[2] Asking the patient about pain directly rather than relying on the patient to volunteer the information improves den detection of pain.[16]"
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society. CMS, Minimum Data Set, Version 3.0 (MDS 3.0) Baltimore MD: Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 11: Wie oft sollte ein Screening stattfinden?
Seite: 107 & 110
Zitat (in Originalsprache): 2 "Baseline scores should be collected for each individual (ideally on a regular basis which would allow for the examination of unusual changes from the persons typical pattern of scores). 3 (...) 4 Because of the high prevalence of pain among persons ith dementia, it is recommended that older adults in long-term care be assessed for pain within 24 hours of admission and no less than once a week for the duration of their stay."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1–S43.

Horgas et al._2008
Horgas, A.L., Yoon,S,L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T. (ed.). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.

Frage 11: Wie oft sollte ein Screening stattfinden?

Seite: 4

Zitat (in Originalsprache):
"Assess pain regularly and frequently to facilitate appropriate treatment (AGS, 2002 **[Level VI]**)."

Evidence-Grad: **[Level V]**
Empfehlungsstärke: nicht ausgewiesen

Referenzen:
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 11: Wie oft sollte ein Screening stattfinden?

Seite: 10 & 38

Zitat (in Originalsprache):
"Screen all persons at risk for pain at least once a day (…). "

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: C

Referenzen:
American Pain Society. (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS).
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
Cavender, K., Goff, M.D., Hollon, E.C., Guzzetta, C.E. (2004). Parents' positioning and distracting children during venipuncture: Effects on children's pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56.
Davis, M., Walsh, D. (2004). Cancer pain: How to measure the fifth vital sign. Cleveland Clinic Journal of Medicine; 71 (8): S. 625-632.
Malviya, S., Voepel-Lewis, T., Burke, C., Merkel, S., Tait, A.R. (2006). The revised FLACC observational pain tool: Improved reliability and validity for pain assessment in children with cognitive impairment. Paediatric Anaesthesia; 16 (3): S. 258-65.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 4 (Kurzversion)
Zitat (in Originalsprache): “Conduct an initial review to determine whether the characteristics and causes of the patient's pain have been Identified. (…) using either a numerical score or a verbal visual descriptor that ist appropriate for and preferred by the patient (…).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 10
Zitat (in Originalsprache): “Herr et al [28] reviewed the use of tools that could be used for severe cognitive impairment and recommended the PAIN-AD (Pain Assessment in Advanced Dementia) and PACSLAC (Pain Assessment Checklist for Seniors with Limited Ability to Communicate) tools. The Abbey pain scale is another tool that can be used in patients who cannot verbalize. [29] Some literature suggests that elderly patients may prefer numerical pain scales presented vertically rather than horizontally. [30] The Iowa Pain Thermometer is one such tool. [31]”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [28] Herr, K., Bursch, H., Ersek, M. et al. (2010). Use of pain-behavioral assessment tools in the nursing home: Expert consensus recommendations for practice. J Gerontol Nurs; 36: S. 18-29; quiz 30-11. [29] Abbey, J., Piller, N., De Bellis, A. et al. (2004). The Abbey pain scale: Al-minute numerical indicator for people with end-stage dementia. Int J Palliat Nurs; 10: S. 6-13. [30] Herr, K.A., Mobily, P.R. (1993). Comparison of selected pain assessment tools for use with the elderly. Appl Nurs Res; 6: S. 39-46. [31] Herr, K., Spratt, K.F., Garand, L., Li, L. (2007). Evaluation of the Iowa pain thermometer and other selected pain intensity scales in younger and older adult cohorts using controlled c1inical pain: A preliminary study. Pain Med; 8: S. 585-600.

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 44
Zitat (in Originalsprache): “Examples of Pain Scales Appropriate for Patients With Cognitive Impairment A. Pain Assessment in Advanced Dementia (PAIN·AD) Scale [(Warden et al., 2003)] (…) B. FACES Pain Rating Scale [(Hockenberry et al., 2005)] (...) c. Noncommunicative Patient's Pain Assessment Instrument (NOPPAIN) [(Snow et al., 2004)] (…) D. Iowa Pain Thermometer [(Herr et al., 2007)] (…) E. Abbey Pain Scale [(Abbey et al., 2004)] “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Warden, V., Hurley, A.C., Volicer, l. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. J Am Med Dir Assoc; 4 (1): S. 9-15.
Hockenberry, N.U., Wilson, D., Winkelstein, M.L. (2005). Wong's essentials of pediatric nursing, 7th ed. St. Louis: Mosby, p. 1259. Used with permission. © Mosby.
Snow, A.l., Weber, J.B., O'Mailey, K.J. et al. (2004). NOPPAIN: A nursing assistant-administered pain assessment instrument for use in dementia. Dement Geriatr Cogn Disord; 17 (3): S. 240-246.
Herr, K., Spratt, K.F.I., Garand, L., Li, L. (2007). Evaluation of the Iowa pain thermometer and other selected pain intensity scales in younger and older adult cohorts using controlled clinical pain: a preliminary study. Pain Med; 8 (7): S.585-600.
Abbey, J., Piller, N., De Bellis, A. et al. (2004). The Abbey pain scale: a l-minute numerical indicator for people with endstage dementia. Int J Palliat Nurs; 10: S. 6-13.

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

Seite: 7

Zitat (in Originalsprache):
"In addition to asking a person about pain, the use of an intensity rating scale will enhance the detection of pain. "

Evidence-Grad und/oder Empfehlungsstärke:
Zitat wird als evidence based statements / nicht als recommendation ausgewiesen.

Referenzen: nicht ausgewiesen

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

Seite: 16

Zitat (in Originalsprache):
"There is no evidence that any one multi-dimensional assessment tool is better than another"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

Seite: 18-20

Zitat (in Originalsprache):
Observational assessment of pain
"In the presence of cognitive impairment, behavioural measures of pain can be used with moderate to reasonable interrater reliability, but even in cognitively intact older adults they are not a good measure of intensity[77].
Several systematic reviews have recently reviewed behavioural pain assessment tools for use in non-verbal older adults and older adults with dementia[35,49,78.] Results indicate that behavioural pain assessment tools are still in the early stages of development and evaluation. Reliability and validity data are limited or still unavailable for many instruments.
The Discomfort Scale-Dementia of Alzheimer Type (DS-DAT) was developed and evaluated in nursing home residents in whom the tool had reasonable reliability and validity. Significant increases in scores were noted during fever[79].

However, the administration and scoring of DS–DAT is quite complex and requires considerable training. There are no observations of the patient during activity which is a further limitation of this particular tool.
The Abbey Pain Scale, developed for end-stage dementia, was built on the DS-DAT and used the Delphi technique across experts from the US and Australia to identify parameters. It was piloted in 52 residents, modified and evaluated in 61 residents. Internal consistency reliability was reasonable (Cronbach's alpha 0.74), but interrater reliability poor[80].
The PAINAD Scale is a simple 5 item observational tool, developed and validated in 19 residents with advanced dementia[81]. Validation studies have confirmed the potential for this scale[82]. The PAINAD covers only a limited number of non-verbal pain behaviours. It is short and easy to use but it needs to be evaluated more widely to assess its sensitivity for pain in clinical settings, as it doesn't appear to be comprehensive.
The Pain Assessment Check List for Seniors with Severe Dementia (PACSLAC) includes a total of 60 items covering subtle as well as common pain behaviours. The tool appears comprehensive and yet easy to use with good internal consistency[83]. A recent prospective evaluation in Dutch nursing home residents revealed good validity and reliability, and nurses considered it easy to use[84].
The NOPAIN tool involves observing patients' pain behaviours (verbalisation, vocalisation, face, bracing, rubbing and restlessness) during activities of daily living such as bathing and dressing[85]. The tool has been evaluated in the US and interrater reliability and construct validity appear to be reasonable. Herr et al felt that the tool shows promise in that it appears easy to use but it is not very comprehensive so further evaluation in clinical settings is needed[35].
DOLOPLUS 2 is a French tool developed for the multidimensional assessment of pain and includes items covering somatic, psychomotor and psychosocial reactions to pain[86]. The French version has been evaluated in several clinical settings and appears to have reasonable internal consistency, interrater reliability and test-retest reliability. However there has been a very limited evaluation of this tool in English and there may therefore be translation issues. It needs to be evaluated further in English speaking populations and this is currently underway.
All these instruments include different combinations of observations which are potentially indicative of the presence of pain[35,87]. Seven main types of observation occur within these pain assessment tools:

1. Physiological observations e.g. breathing pattern, sweating
2. Facial expressions e.g. wincing, grimacing, frowning, rapid blinking.
3. Body movements e.g. guarding, altered gait, pacing, rocking, hand wringing, repetitive movements.
4. Verbalisations / vocalisations e.g. moaning, groaning, asking for help, screaming, aggressive or offensive speech.
5. Changes in interpersonal interactions e.g. aggression, withdrawal, resisting care.
6. Changes in activity patterns or routines e.g. wandering, altered sleep pattern, altered rest patterns.
7. Mental status changes e.g. crying, tears, increased confusion, irritability.

There is as yet no single instrument that has been shown to have psychometric properties sufficient for it to be recommended for general clinical use. Detailed critiques can be found elsewhere[35,49,78.]
As indicators of pain, these observations/ behaviours will vary substantially between individuals. Familiarity with patients, together with information from carers about the significance of certain behaviours, should help clinicians to interpret them. We recommend that carers become familiar with these behaviours/observations in their patients and monitor carefully so that alterations in behaviour/observations are detected promptly. The presence of observational indicators of possible pain should prompt a more detailed clinical assessment.

Recommendations
In older people with cognitive impairment or with difficulty in communication, observational assessment becomes essential for assessing the presence of pain.
Carers familiar with older people with cognitive impairment should be included in the assessment of their pain."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[35.] Herr, K., Bjøro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: a state of the science review. Journal of Pain and Symptom Management; 31 (2): S. 170-192.

[49.] Stolee, P., Hillier, L.M. et al. (2005). "Instruments for the assessment of pain in older persons with cognitive impairment." J Am Geriatr Soc; 53 (2): S. 319-326.

[77.] Kaasalainen, S., Crook, J. (2003). A comparison of pain assessment tools for use with elderly long term care residents. Canadian Journal of Nursing Research; 35 (4): S.58-71.

[78.] Zwakhalen, S.M.G., Hamers, J.P.H., Abu-Saad, H.H., Berger, M.P.F. (2006). Pain in elderly people with severe dementia: A systematic review of behavioural pain assessment tools. BMC Geriatrics; 6: S. 3.

[79.] Hurley, A.C., Volicer, B.J., Hanrahan, P.A., Houde, S., Volicer, L. (1992). Assessment of discomfort in advanced Alzheimer patients. Research in Nursing and Health: 15: S. 369-377.

[80.] Abbey, J., Piller, N., De Bellis, A., Esterman, A., Parker, D., Giles, L., Lowcay, B. (2004). The Abbey Pain Scale: A one minute indicator for people with end stage dementia. International Journal of Palliative Nursing; 10 (1): S. 6-13.

[81.] Warden, V., Hurley, A.C., Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. Journal of the American Medical Directors Association; 4: S. 9-15.

[82.] Ian Yi-Onn, L., Mei Sian, C., Stephen, J.G. (2006) The use of a self-reported pain measure, a nurse-reported pain measure and the PAINAD in nursing home residents with moderate and severe dementia: a validation study Age and Ageing; 35 (3): S. 252-256.

[83.] Fuchs-Lacelle, S., Hadjistavropoulos, T. (2004). Development and preliminary validation of the pain assessment checklist for seniors with limited ability to communicate (PACSLAC). Pain Management Nursing; 5 (1): S. 37-49.

[84.] Zwakhalen, S.M., Hamers, J.P., Berger, M.P. (2006). The psychometric quality and clinical usefulness of three pain assessment tools for elderly people with dementia. Pain; 126: S. 210–220.

[85.] Snow, A.L., Weber, J.B., O'Malley, K.J., Cody, M., Beck, C., Bruera, E., Ashton, C., Kunik, M.E. (2004). NOPAIN: a nursing assistant-administered pain assessment instrument for use in dementia. Geriatric Cognitive Disorders; 17: S: 240-246.

[86.] Lefebvre-Chapiro, S. (2001). The Doloplus Group. The DOLOPLUS-2 scale- evaluating pain in the elderly. European Journal of Palliative Care; 8: S. 191-194.

[87.] AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.

Hadjistavropoulos et al._2010
Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

Seite: 108

Zitat (in Originalsprache):
"Observational tools that have been shown to be reliable and valid for use in this population include the PACSLAC and DOLOPLUS-2."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., K. Herr, et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: S3
Zitat (in Originalsprache): “Where brief assessment tools are needed, the VDS and the NRS are, generally, recommended for the assessment of pain intensity among seniors who are cognitively intact and can self-report.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 5
Zitat (in Originalsprache): “One of the 3 following Pain Rating Scales shall be used as appropriate for the individual resident: 1. Wong-Baker Scale 2. Numerical Scale 3. FLACC Scale If the resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal resident. Additionally, the facility shall seek information from the resident’s family, caregiver or other representative, if available and known to the facility.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 11
Zitat (in Originalsprache): „Resident Interview Interviewer Observation

PAIN SCREEN Date_____/_____/_____

Resident Name_____ Age_____ Room_____

Diagnosis_____

Physician_____ Nurse_____

Objective: This interview will help to identify the level of pain education and history of the resident to provide optimal resident comfort in the process of easing, controlling and/or diminishing pain. The following documentation may be mutually established with the help of the resident, family members and staff. If the resident is *non*verbal, ask a family member or significant other if they can answer any of the questions. If not, note "not able to obtain from resident or significant other."

Who Answered the following questions:

☐Resident Family Member (name)_____ Relationship to Resident:_____

RESIDENT INTERVIEW:

1. Do you have pain now? ☐Yes ☐No ☐If yes, PAIN SCORE of _____ using: ☐Wong-Baker ☐Numerical ☐FLACC
2. Do you ever have pain? ☐Yes ☐No ☐If Yes, how often and where: _____
3. Within the last two weeks, have you taken any medications or treatments to control pain? ☐Yes ☐No ☐If yes, list details:
4. Are you able to report your pain to the nurse? ☐Yes ☐No ☐If No, why not: _____
5. Do you feel that it is normal to have pain? ☐Yes ☐No ☐If No, why not: _____
6. Do you feel that all pain should be treated? ☐Yes ☐No ☐If No, why not: _____
7. Do you have any cultural or religious beliefs that would influence the management of pain? ☐Yes ☐No
   ☐If Yes, please explain: _____
8. How intense does your pain need to be to be treated? ☐Rate on a Scale of 1—10_____ Or, explain: _____
9. How have you treated your pain in the past? (Explain) (medications, other modalities): _____
10. Have you ever used alcohol to relieve your pain? ☐Yes ☐No
11. What drugs, legal or illegal, have you used in the past to relieve your pain? ☐None List drugs: _____

INTERVIEWER OBSERVATIONS:

1. If the resident is not able to describe pain, please check below if there are any current *non*verbal signs of pain:
   ☐Moaning/Yelling ☐Rocking ☐Restless Movements ☐Combative ☐Grimacing ☐Guarding ☐Rubbing Area
   ☐*No Signs of pain* ☐Other: _____
2. EDUCATION: ☐Resident educated to report pain to the nurse ☐Family/significant other educated to report signs of resident's pain to the nurse ☐Family/significant other not available at admission to discuss/educate re: pain management
3. OTHER OBSERVATIONS: _____

"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Herr et al._2006

Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

Seite: 55

Zitat (in Originalsprache):

"APPENDIX A

INITIAL PAIN ASSESSMENT TOOL

(Adapted from McCaffery & Pasero, 1999 with permission)"

Evidence-Grad: siehe Referenzen Vb

Empfehlungsstärke: nicht ausgewiesen

Referenzen:

McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual. 2nd ed. St. Louis, MO: Mosby. (Vb).

Herr et al._2006

Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 12: Welche Instrumente sind für ein Screening geeignet?

Seite: 13-14

Zitat (in Originalsprache):

"Assess pain intensity by selecting a tool based on the patient's preferences and cognitive/functional abilities, and then use the same tool consistently. Most older adults can use pain scales, depending on individual cognitive, education, psychomotor and sensory factors. Numeric rating scales, verbal descriptor scales, pain thermometers, and faces pain scales have acceptable validity and are preferred by many older adults. If the older adult is alert and oriented, use a 0-10 Numeric Rating Scale. If unsuccessful, try a Verbal Descriptor Scale or Faces Pain Scale (AGS, 2002; Bergh et al., 2000, 2001; Carey et al., 1997; Choiniere & Amsel, 1996; Feldt et al., 1998a; Gagliese & Katz, 2003; Gagliese et al., 2005; Herr & Mobily, 1993; Herr et al., 1998a; Herr et al., 2004b; Kaasalainen & Crook, 2004; Pautex et al., 2005; Stuppy, 1998; VHA/DoD, 2002; Weiner et al., 1998b; Zalon, 1999).**—B**

- **Numeric Rating Scales (**NRS)
- **Six-point Numeric Rating Scale (**NRS 0-5) (Morrison et al., 1998).—**C**
- **Eleven-point Numeric Rating Scale (**NRS 0-10) (Bergh et al., 2000, 2001; Closs et al., 2004; Gagliese et al., 2005; Kaasalainen & Crook, 2004; VHA/DoD, 2002).—**B**
- **Twenty-one point Numeric Rating Scale (**NRS 0-20) (Chibnall & Tait, 2001; Herr et al., 2004b; Taylor & Herr, 2003).**—B**
- **Verbal Descriptor Scale (VDS) appears to be easiest and most preferred by older adults and easiest for those with cognitive impairment (**Bergh et al., 2000, 2001; Closs et al., 2004; Gagliese & Katz, 2003; Herr et al., 2004b; Manz et al., 2000; Taylor & Herr, 2003).**—B**
- **Four-point Verbal Rating Scale (**VRS) (Closs et al., 2004).—**C**
- **Pain Thermometer (**PT) (Herr & Mobily, 1993; Taylor & Herr, 2003).—**B**
- **Present Pain Inventory Scale (PPI) (**Gagliese & Katz, 2003; Gagliese et al., 2005; Kaasalainen & Crook, 2004; Melzack & Katz, 1992; Pautex et al., 2005).**—C**
- **Seven-point Graphic Rating Scale (GRS) (**Bergh et al., 2000, 2001).—**B**
- **Faces Rating Scales**
- **Faces Pain Scale (FPS) (**Bieri et al., 1990; Closs et al., 2004; Freeman et al., 2001; Herr et al., 2004b; Kaasalainen & Crook, 2004; Stuppy, 1998; Taylor & Herr, 2002, 2003).**—B**
- **Wong-Baker FACES** pain rating scale (Wong & Baker, 1988; Wong & Baker, 1995; Wynne et al., 2000).**—C**

• Faces Pain Scale is not equivalent in numbering to NRS or VAS, thus it cannot be assumed that a 6 on the FPS is equal to a 6 on NRS (Freeman et al., 2001; Gagliese & Katz, 2003).—**C**

• When faces scales are used, the patient should be taught to select the face that most represents the way they think they are feeling, not the way they think they look (Pasero, 2005).—**E** (See Appendix C for examples of pain intensity tools recommended for use with older adults.)."

Evidence-Grad: siehe Referenzen II -V
Empfehlungsstärke: B, C & E

Referenzen:

AGS (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a).

Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patients. Aging-Clinical & Experimental Research; 12 (5): 380-387. (III-a).

Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2001). Assessing pain and pain relief in geriatric patients with non-pathological fractures with different rating scales. Aging-Clinical & Experimental Research; 13 (5): S. 355-361. (III-a).

Bieri, D., Reeve, R.A., Champion, G.D., Addicoat, L., Ziegler, J.B. (1990). The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: Development, initial validation, and preliminary investigation for ratio scale properties. Pain; 41: S. 139-150. (III-b).

Carey, S.J., Turpin, C., Smith, J., Whatley, J., Haddox, D. (1997). Improving pain management in an acute care setting: The Crawford Long Hospital of Emory University experience. Orthopaedic Nursing; 16 (4): S. 29-36. (III-a).

Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92 (1-2): S. 173-186. (III-a).

Choiniere, M., Amsel, R. (1996). A visual analogue thermometer for measuring pain intensity. Journal of Pain and Symptom Management; 11 (5): S. 299-311. (III-b).

Closs, S. J., Barr, B., Briggs, M., Cash, K., Seers, K. (2004). A comparison of five pain assessment scales for nursing home residents with varying degrees of cognitive impairment. Journal of Pain & Symptom Management; 27 (3): 196-205. (III-a).

Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a).

Freeman, K., Smyth, C., Dallam, L., Jackson, B. (2001). Pain measurement scales: a comparison of the Visual Analogue and Faces Rating Scales in measuring pressure ulcer pain. Journal of WOCN; 28 (6): S. 290-296. (III-a).
Gagliese, L., Katz, J. (2003). Age differences in postoperative pain are scale dependent: a comparison of measures of pain intensity and quality in younger and older surgical patients. Pain; 103 (1-2): S. 11-20. (II-a).
Gagliese, L., Weizblit, N., Ellis, W., Chan, V.W.S. (2005). The measurement of postoperative pain: A comparison of intensity scales in younger and older surgical patients. Pain; 117 (3): 412-420.
Herr, K.A., Mobily, P.R. (1993). Comparison of selected pain assessment tools for use with the elderly. Applied Nursing Research; 6 (1): S. 39-46. (III-a).
Herr, K.A., Mobily, P.R., Kohout, F.J., Wagenaar, D. (1998a). Evaluation of the Faces Pain Scale for use with the elderly. Clinical Journal of Pain; 14 (1): S. 29-38. (III-a).
Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004b). Pain intensity assessment in older adults. Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20 (4): S. 207-219. (II-a).
Kaasalainen, S., Crook, J. (2004). An exploration of senior's ablity to report pain. Clinical Nursing Research; 13 (3): S. 199-215. (III-a).
Manz, B.D., Mosier, R., Nusser-Gerlach, M.A., Bergstrom, N., Agrawal, S. (2000). Pain assessment in the cognitively impaired and unimpaired elderly. Pain Management Nursing, 1 (4): S. 106-115. (III-a).
Melzack, R., Katz, J. (1992). The McGill Pain Questionnaire: Appraisal & Current Status. In D. C. Turk & R. Melzack (Eds.), Handbook of Pain Assessment: S. 152-168. New York: Guilford. (IV-b).
Morrison, R.S., Ahronheim, J.C., Morrison, G.R., Darling, E., Baskin, S.A., Morris, J., Choi, C., Meier, D.E. (1998). Pain and discomfort associated with common hospital procedures and experiences. Journal of Pain & Symptom Management; 15 (2): S. 91-101. (III-a).
Pasero, C. (2005). Personal communication.
Pautex, S., Herrmann, F., Le Lous, P., Fabjan, M., Michel, J.P., Gold, G. (2005). Feasibility and reliability of four pain self-assessment scales and correlation with an observational rating scale in hospitalized elderly demented patients. Journals of Gerontology Series A: Biological Sciences & Medical Sciences; 60A (4): S. 524-529. (III-a).
Stuppy, D.J. (1998). The Faces Pain Scale: Reliability and validity with mature adults. Applied Nursing Research; 11 (2): S. 84-89. (III-a).
Taylor, L.J., Herr, K. (2002). Assessment. Evaluation of the Faces Pain Scale with minority older adults. Journal of Gerontological Nursing; 28 (4): S. 15-23. (III-a).
Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African American older adults. Pain Management Nursing; 4 (2): S. 87-95. (III-a).
VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain.Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).
Weiner, D.K., Peterson, B.L., Logue, P., Keefe, F.J. (1998b). Predictors of pain self-report in nursing home residents. Aging: Clinical and Experimental Research; 10: S. 411-420. (III-a).
Wong, D., Baker, C. (1988). Pain in children: comparison of assessment scales. Pediatric Nursing; 14: S. 9-17. (III-b).
Wong, D., Baker, C. (1995). Reference Manual for the Wong-Baker FACES pain rating scale. Tulsa, OK: Wong & Baker. (V-b).
Wynne, C.F., Ling, S.M., Remsburg, R. (2000). Comparison of pain assessment instruments in cognitively intact and cognitively impaired nursing home residents. Geriatric Nursing; 21 (1): S. 20-23. (III-a).
Zalon, M.L. (1999). Comparison of pain measures in surgical patients. Journal of Nursing Measurement; 7 (2): S. 135-152. (III-a).

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 10 & 38
Zitat (in Originalsprache) “All patients at risk should be screened including vulnerable populations (e.g. neonates, infants, children, elderly, non-communicative, cognitively impaired patients, those with life threatening illness) using a validated intensity tool e.g. (0-10).”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: AHCPR (1994). Clinical practice guideline; 9. Publication Number 94-0592.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 12: Welche Instrumente sind für ein Screening geeignet?
Seite: 44
Zitat (in Originalsprache): “Er is ook nog een kortere BPI ontwikkeld en gevalideerd: de PEG (Krebs et al, 2009) met slechts drie vragen, die met name in de eerste lijn veelbelovend lijkt. Een kortere screenende vragenlijst zoals de PEG heeft in de implementatie waarschijnlijk meer kans van slagen dan de uitgebreidere BPI, zeker bij een zo prevalent probleem als (chronische) pijn.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Krebs, E.E., Lorenz, K.A., Bair, M.J., Damush, T.M., Wu, J., Sutherland, J.M., Asch, S.M., Kroenke, K. (2009). Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med.; 24 (6): S. 733-738.

Frage 13: Welchen Nutzen haben Screeninginstrumente hinsichtlich der Versorgungsqualität der Bewohner?

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 13: Welchen Nutzen haben Screeninginstrumente hinsichtlich der Versorgungsqualität der Bewohner?
Seite: 8
Zitat (in Originalsprache): “The use of a standardized assessment tool that has been found to be valid and reliable with older adults is important. In a review of the literature on pain in nursing homes, Swafford et al.18 found that pain management improved in nursing homes that documented the use of a comprehensive pain assessment tool.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [18.] Swafford, K.L., Miller, L.L., Tsai, P. et al. (2009). Improving the process of pain care in nursing hornes: A literature synthesis. J Am Geriatr Soc; 57: S. 1080-1087.
Ggf. weitere Bemerkungen Es wird „assessment tool“ benannt, die Aussage steht aber im Zusammenhang mit der „Recognition“ die nach dieser LL vor dem Assessment erfolgt und daher mit dem Screening vergleichbar ist.

Frage 14: Wer sollte nach Schmerzen screenen?

AGS 2002 AGS Panel on Persistent Pain in Older Persons. (2002) The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 208
Zitat (in Originalsprache): “(…) any healthcare service, a healthcare professional (…).”
Evidence-Grad: II Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: ii
Zitat (in Originalsprache): “CPGs addresses many functions and tasks related to recognizing, clarifying, managing, and monitoring various medical conditions and situations. The guidelines focus on process (what should be done) rather than on personnel (who should perform specific tasks). For example, staff members from many disciplines working in the LTC setting, including nursing assistants, licensed nurses, dietitians, and social workers, ma make and document observations (e.g. that a patient does not sleep at night has become more withdraw , or has a change in usual eating patterns). Only some of these disciplines, however, may be qualified to determine this significance of those observations (e.g. the cause of sleeplessness or a change in change in eating patterns). In contrast, practitioners may not be present to make observations, but are trained to analyze the significance and causes of symptoms. Thus, each facility should ensure that tasks are done correctly and by the appropriate interdisciplinary team members. It is important for observers to make and effectively document their observations; when interpretation of those observations is not within the scope of their training or practice, they should receive appropriate support from practitioners.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 8
Zitat (in Originalsprache): “Nursing assistants and activities staff are often the first to recognize nonspecific signs and symptoms of pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 12
Zitat (in Originalsprache): “Families can be a useful additional source of information with the older person’s consent.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 105 & 111
Zitat (in Originalsprache): “From a physiotherapy standpoint, assessment of pain is critical (Lit.-quelle). The pain-assessment guidelines summarized in Table 1 are aimed at facilitating physiotherapy evaluations of long-term care patients.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Scudds, R.J., Scudds, R.A. (2005). Physical therapy approaches to the management of pain in older adults. In: Gibson S, Weiner D, editors. Pain inolder persons. Seattle: IASP Press: S. 223–37.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: S4
Zitat (in Originalsprache): “Interdisciplinary evaluation and collaboration are often necessary to address the full range of the older person’s health-related circumstances.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 5
Zitat (in Originalsprache): “If the resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal resident. Additionally, the facility shall seek information from the resident’s family, caregiver or other representative, if available and known to the facility.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 8
Zitat (in Originalsprache): “Pain Assessment may involve collaboration with physicians, nurses and other health care providers.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS. RCP_2007 & Royal College of Physicians, British Geriatric Society et al. (2007). The Assessment of Pain in Older People: National Guidelines. Concise guidance to good practice series No 8. London, Royal College of Physicians.)
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 5 (RCP_2007)
Zitat (in Originalsprache): “All healthcare professionals should be alert to the possibility of pain in older people, and to the fact that older people are often reluctant to acknowledge and report pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 14: Wer sollte nach Schmerzen screenen?
Seite: 40
Zitat (in Originalsprache): “Health professionals should ask about pain and (…).”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: AHCPR (1994). Clinical practice guideline; 9. Publication Number 94-0592.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 14: Wer sollte nach Schmerzen screenen?
Seite: 23 (Teil II)
Zitat (in Originalsprache): “Familieleden van de patiënt zijn onmisbaar voor de pijnmeting bij ouderen die moeilijk verbaal kunnen communiceren. De oordelen van artsen, therapeuten en verzorgers (verzorgend personeel en familieleden) kunnen het best gecombineerd worden voor een betrouwbare inschatting van de pijnbeleving bij de ouderen met communicatieve stoornissen (Herr et al, 2006). Familieleden weten wat gebruikelijke en vroegere pijngedragingen zijn van de patiënt, zodat zij subtiele gedragsveranderingen kunnen herkennen en kunnen oordelen of deze gerelateerd zijn aan pijn (Herr et al, 2006).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Herr, K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older·adults with dementia: a state-ot-the-science review. J Pain Symptom Manage; 31: S. 170-192. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs; 7: S. 44-52. doi:10.1016/j.pmn.2006.02.003.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 14: Wer sollte nach Schmerzen screenen?
Seite: 32 (Teil II)
Zitat (in Originalsprache): “Aanbeveling:

Raadpleeg –zo mogelijk met toestemming van de kwetsbare oudere– de familie, de wettelijk vertegenwoordiger of de verpleegkundigen en verzorgenden voor extra informatie over de mogelijke aanwezigheid van pijn (heteroanamnese). Vooral bij kwetsbare ouderen met ernstige cognitieve/ communicatieve beperkingen is dit van belang.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 14: Wer sollte nach Schmerzen screenen?
Unklar, aber im Text werden unterschiedliche Gruppen als verantwortlich definiert
Seite: 93
Zitat (in Originalsprache): „Vertaald naar de Nederlandse situatie betekent dit voor de thuissituatie, dat de huisarts, praktijkondersteuner of indien betrokken de wijkverpleegkundige (of een andere HBO-opgeleide zorgverlener) als coördinator optreedt. Daarnaast bestaat het team uit: huisarts, apotheker, (geriatrie-)fysiotherapeut en eventueel specialist ouderengeneeskunde, (ouderen)psycholoog, diëtist en ergotherapeut. Hoofdverantwoordelijke voor signalering en diagnostiek kan deze teamleider (wijkverpleegkundige of praktijkondersteuner) zijn als een door de huisarts aan hem gedelegeerde taak. Voor behandeling is de huisarts hoofdverantwoordelijke. Het is lastiger (met name voor het signaleren van pijn) wanneer het mensen betreft, die weinig of geen zorg vragen.“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 15: Welche Konsequenz sollte das Screening der Bewohner haben?

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 15: Welche Konsequenz sollte das Screening der Bewohner haben?
Seite: 10
Zitat (in Originalsprache): **"STEP 3** Provide appropriate interim treatment for pain. If a patient is experiencing pain that is not being treated or is not adequately relieved by existing therapies, the practitioner should adjust or prescribe a pain relief regimen to maximize the patient' s comfort and minimize side effects while actively assessing the patient for underlying causes of the pain. Patients with acute injury should receive pain medication while awaiting diagnostic testing or transfer to the emergency department. A relevant study showed that morphine given to patients with acute abdominal pain did not adversely affect the ability to make an accurate diagnostic assessment.[32]"
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [32.] Thomas, S.H., Silen, W., Cheema, F. et al. (2003). Effects of morphine analgesia on diagnostic accuracy in emergency department patients with abdominal pain: A prospective, randomized trial. J Am Coll Surg; 196: S. 18-31.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007) A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 15: Welche Konsequenz sollte das Screening der Bewohner haben?
Seite: 9
Zitat (in Originalsprache): "The identification of behavioural indicators of possible pain should prompt a more detailed clinical assessment[35]."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [35.] Herr, K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: a state of the science review. Journal of Pain Symptom Management; 31 (2): S. 170-192.

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 15: Welche Konsequenz sollte das Screening der Bewohner haben?
Seite: 6
Zitat (in Originalsprache): "A complete Pain Assessment shall be done if the Pain Rating Scale score is above 0 in the circumstances listed in II-B, no. 1-5. In nursing facilities, a complete Pain Assessment shall be completed at the time of the quarterly MDS if pain has been recorded. In assisted living facilities, the semi-annual wellness nursing assessment shall include a pain rating scale. If greater than 0, a Pain Assessment shall be completed. In residential health care and adult day health services, a Pain Assessment shall be completed when pain is reported, and should be completed at least annually thereafter."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 15: Welche Konsequenz sollte das Screening der Bewohner haben?
Seite: 15
Zitat (in Originalsprache): **“Treat pain prior to completing comprehensive pain assessment (**VHA/DoD, 2002).**—D”**
Evidence-Grad. siehe Referenzen IV-b Empfehlungsstärke: D
Referenzen: VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?

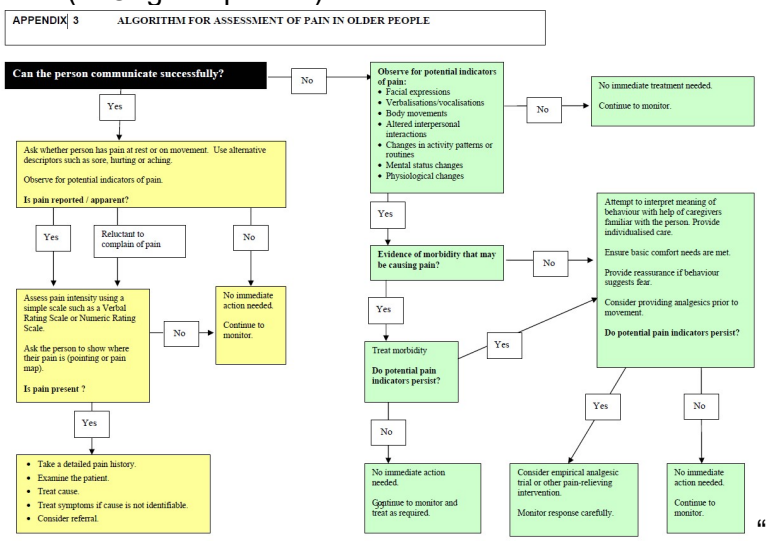
AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Seite: 6
Zitat (in Originalsprache): “Communication. Staff members should communicate information about a patient's pain in a timely fashion to those who will act upon the information. Facilities should consider the following actions: • Adopt a patient-centered approach that promotes the patient's involvement, to the extent feasible, in the pain management care plan, including setting specific pain goals, the choice of an assessment scale, and the choice of nonpharmacologic and pharmacologic treatment modalities. For example, this should include the use of an "1" care plan in which each goal is written in the first person (e.g., "My acceptable level of pain is ... "). • Encourage all members of the interdisciplinary team to use a common vocabulary to describe pain and a standard set of pain assessment tools that are understood by everyone who uses them. • Document ongoing pain assessment and the effectiveness of all treatments in every patient's medical record. • Establish a systematic approach to care, such as making pain assessment a routine part of every care plan meeting. • Establish an inclusive approach to care that includes seeking the input of the patient, of family members, and of direct care staff who are familiar with the patient-including the nursing assistant, who usually knows the patient best and spends the most time with the patient. • Designate a staff member who is accountable for ensuring that all patients are properly assessed or evaluated for pain and receive adequate, appropriate treatment. • Instruct Minimum Data Set (MDS) coordinators who are reviewing and recording all aspects of patient care to communicate to the practitioner if they note a patient who is in significant pain often. • Ensure that the facility' s processes for assessing and evaluating patients, reporting critical information, and obtaining timely responses from practitioners function optimally. • Consider pain management as a standard quality improvement program.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?

Seite: 3

Zitat (in Originalsprache):“



“

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007
Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.

Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?

Seite: S5

Zitat (in Originalsprache):“

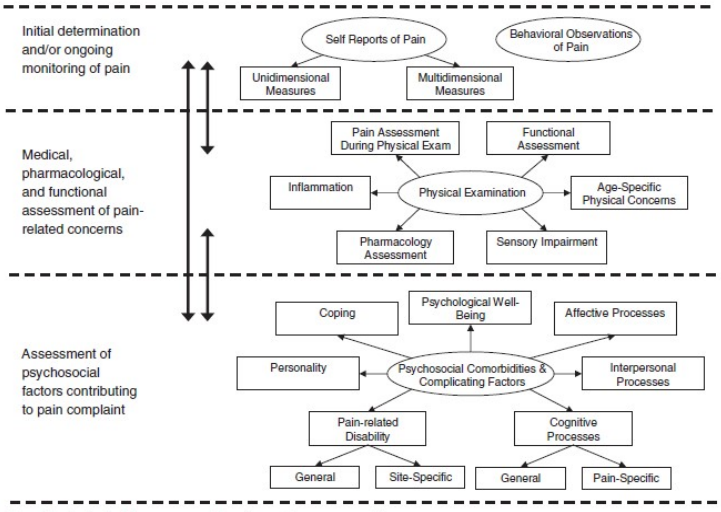


FIGURE 1. Domains included in a comprehensive pain assessment.
“

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Seite: 5
Zitat (in Originalsprache): "(…) upon day of planned discharge (send a copy with the resident)."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Seite: 8
Zitat (in Originalsprache): "Pain Assessment may involve collaboration with physicians, nurses and other health care providers."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Seite: 6 (Version 2007)
Zitat (in Originalsprache): "[14.] Communicate to members of the interdisciplinary team pain assessment findings by describing parameters of pain obtained through the use of a structured assessment tool, the relief or lack of relief obtained from treatment methods and related adverse effects, person's goals for pain treatment and the effect of pain on the person."
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39. Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90. van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Seite: 93
Zitat (in Originalsprache): “De coördinator van het pijnteam in het verzorgingshuis, of indien dit team er (nog) niet is de met pijnmanagement belaste verpleegkundige, is verantwoordelijk voor het regelmatig laten uitvoeren van pijnmetingen bij alle patiënten en voor het laten terugkoppelen van de resultaten van de metingen naar de behandelend arts. Ook het regelen van pijnmeetinstrumenten, het verzorgen van deskundigheidsbevordering en kwaliteitsmetingen is een taak van de coördinator van dit pijnteam. Het team is ook beschikbaar voor consultatie van individuele patiënten. Deze verantwoordelijkheid is gedelegeerd door de directie.″
Deutsche Formulierung der Empfehlung: Der Koordinator des Schmerzteams im Pflegeheim, oder wenn dieses (noch) nicht eingesetzt ist, die für das Schmerzmanagement zuständige Pflegefachkraft. ist für die regelmäßige Durchführung der Schmerzmessungen bei allen Patienten und für die Rückkoppelung der Resultate der Schmerzerfassungen mit dem behandelnden Arzt verantwortlich. Auch das Management der Schmerzerfassungsinstrumente, die Bereitstellung von Fachkennnissen und Qualitätsmessungen ist eine Aufgabe des Koordinators des Schmerzteams. Das Team steht auch für Konsultationen mit den einzelnen Patienten zur Verfügung. Diese Verantwortung ist durch den Vorstand/ Leitung delegiert.
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage Nr 16: Welche Kommunikation - und Entscheidungswege (Schnittstellen) sind für das Screening notwendig?
Seite: 94
Zitat (in Originalsprache): “Kwetsbare ouderen in het verpleeghuis In het verpleeghuis is de specialist ouderengeneeskunde de hoofdbehandelaar. Omdat vaak aan een verpleeghuis ook een (ouderen)psycholoog verbonden is, kan deze discipline een belangrijke rol spelen in het pijnteam; psychologische factoren kunnen immers een belangrijke rol spelen in de pijnbeleving, zoals angst, depressie etc. Met name adviezen aan de patiënt voor het omgaan met chronische pijn en omgangsadviezen voor het multidisciplinaire team bij gedragsaspecten, die gerelateerd kunnen zijn aan pijn, kunnen een belangrijke rol spelen bij het zorgen voor een optimaal kwaliteit van leven van patiënten met chronische pijn. De coördinator van het team in het verpleeghuis, bij voorkeur een verpleegkundige, is er verantwoordelijk voor, dat bij iedere patiënt regelmatig pijnmetingen worden uitgevoerd. Daarnaast is de leider van het team verantwoordelijk voor de terugkoppeling van de pijnmetingen naar de behandelend arts. Ook het zorgen voor de aanwezigheid van pijnmeetinstrumenten, het verzorgen van deskundigheidsbevordering en kwaliteitsmetingen is een taak van de leider van dit pijnteam. Het team is ook beschikbaar voor consultatie van individuele patiënten. Deze verantwoordelijkheid is gedelegeerd vanuit de directie.”
Deutsche Formulierung der Empfehlung: Gebrechliche ältere Menschen im Pflegeheim Im Pflegeheim ist der Spezialist in der Geriatrie [eigene Anmerk. Geriater] Hauptbehandler. Ist dem Pflegeheim, ein (Geriatrie spezialisierter) Psychologe angeschlossen, hat diese

Disziplin eine wichtige Rolle im Schmerz-Team; psychologische Faktoren wie Angst, Depression, etc. können eine sehr wichtige Rolle bei der Schmerzempfindung spielen. Insbesondere Beratung des Patienten zum Umgang mit chronischen Schmerzen und Ratschläge für das multidisziplinären Team bei Verhaltensweisen, die mit Schmerz assoziert sein können, spielen eine wichtige Rolle im Sorgen für eine optimalen Lebensqualität von Patienten mit chronischen Schmerzen. Der Koordinator des Pflegeteam, vorzugsweise eine Krankenschwester, ist verantwortlich für regelmäßige Durchführung der Schmerzerfassungen bei allen Patienten und für die Rückkoppelung der Resultate der Schmerzerfassungen mit dem behandelnden Arzt. Auch das Management der Schmerzerfassungsinstrumente, die Bereitstellung von Fachkennnissen und Qualitätsmessungen ist eine Aufgabe des Koordinators des Schmerzes Team. Das Team steht auch für Konsultationen mit den einzelnen Patienten zur Verfügung. Diese Verantwortung ist durch den Vorstand/ Leitung delegiert.
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 17: Wie sollte das Screening dokumentiert werden?

AMDA_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Frage 17: Wie sollte das Screening dokumentiert werden?
Seite: ii
Zitat (in Originalsprache): “Thus, each facility should ensure that tasks are done correctly and by the appropriate interdisciplinary team members. It is important for observers to make and **effectively document their observations;** when interpretation of those observations is not within the scope of their training or practice,they should receive appropriate support from practitioners.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 23.
Frage 17: Wie sollte das Screening dokumentiert werden?
Seite: 5 & 9
Zitat (in Originalsprache): “A Pain Rating Scale shall be completed and documented, (…). Requirements for documentation of a patient’s/resident’s pain status on the medical record; (…).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 17: Wie sollte das Screening dokumentiert werden?
Seite: 4-15
Zitat (in Originalsprache): **“Document pain in a visible place that can be used by other health care providers.** This may be where vital signs are documented or on a separate pain flowsheet. Information important to document includes: date; time; pain intensity rating; quality (e.g., sharp, dull, burning etc.); location; onset and duration; comfort-function goal; analgesic information (e.g., drug, dose, route, frequency); other pain interventions; vital signs and side effects (APS, 2003; Arnstein, 2002; Faries et al., 1991; McCaffery & Pasero, 1999; O'Connor, 2003; VHA/DoD, 2002; Voigt et al., 1995).**—B** (See example of a pain flowsheet in Appendix B.)”
Evidence-Grad: siehe Referenzen II-a – V-b Empfehlungsstärke: B
Referenzen: APS (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (5th ed.). Glenview, Illinois: American Pain Society (APS). (V-b). Arnstein, P. (2002). Optimizing perioperative pain management. AORN Journal; 76: S. 82-818. (V-b). Faries, J.E., Mills, D.S., Goldsmith, K.W., Phillips, K.D., Orr, J. (1991). Systematic pain records and their impact on pain control. Cancer Nursing; 14: S. 306-313. (II-a). McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual. 2nd ed. St. Louis, MO: Mosby. (V-b). O'Connor, M. (2003). Pain management: improving documentation of assessment and intensity. Journal for Healthcare Quality; 25 (1): S. 17-22. (III-b).

VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).
Voigt, L., Paice, J.A., Pouliot, J. (1995). Standardized pain flowsheet: Impact on patient-reported pain experiences after cardiovascular surgery. American Journal of Critical Care; 4: S. 308-313. (II-a).

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 17: Wie sollte das Screening dokumentiert werden?

Seite: 6 (Version 2007)

Zitat (in Originalsprache):
“Document pain assessment regularly and routinely on standardized forms that are accessible to all clinicians involved in care.”

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: C

Referenzen:
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.

5.2 Zitate zur Beantwortung der klinisch relevanten Fragen zum Bereich Assessment von Schmerz bei älteren Menschen in der vollstationären Altenhilfe

Frage 18: Welchen Nutzen hat ein Assessment von Schmerzen im Vergleich zu keinem Assessment für die ausgewählte Population?

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA) Summary 2009 & Volltext 2012
Frage 18 Welchen Nutzen hat ein Assessment von Schmerzen im Vergleich zu keinem Assessment für die ausgewählte Population?
Seite: 11 (2012)
Zitat (Originalzitat): “The appropriate scope of a workup for pain may vary according to the patient’s care goals and prognosis. For example, an extensive diagnostic workup may not be appropriate under the following circumstances: - The patient is at the end of life or has an end-stage condition, - The patient has requested in an advance directive that certain diagnostic procedures not be performed, - Identifying the cause of the pain would not change the patient' s care plan, and - The burdens of a diagnostic workup outweigh the potential benefits that would be derived from determining the reason for the pain. In such circumstances, an evaluation of the effectiveness of appropriate comfort measures may suffice. In contrast, in a patient who is otherwise relatively healthy; a comprehensive evaluation may be indicated to determine the cause of a new onset of pain. For example, - Pain from a witnessed or unwitnessed fall could indicate an orthopedic injury. - Headache pain with vision involvement could indicate temporal arteritis. - Bone pain should raise suspicion of metastasis. - Severe limb pain should raise suspicion of acute vascular events, such as arterial occlusion, embolus, thrombosis, or aneurysm, or neurologic compromise, such as radiculopathy or peripheral nerve entrapment. - Pain in a unilateral dermatomal distribution, even before skin lesions are visible, should raise suspicion of herpes zoster.Regardless of whether diagnostic testing is performed, the practitioner and staff members should try to identify the most likely cause(s) of the patient's pain from the evidence collected from a focused evaluation.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 18 Welchen Nutzen hat ein Assessment von Schmerzen im Vergleich zu keinem Assessment für die ausgewählte Population?
Seite: 12
Zitat (Originalzitat): “Assessment of the pain is important to aid diagnosis, to understand the impact that the pain has on the person, physically, emotionally, functional and socially, to help decide on the choice of therapy and to monitor the effect of treatment.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 18 Welchen Nutzen hat ein Assessment von Schmerzen im Vergleich zu keinem Assessment für die ausgewählte Population?
Seite: S2
Zitat (Originalzitat): “There are several reasons why it is important to assess pain and other symptoms in older adults. First, the data derived from comprehensive assessment are essential not only for diagnostic purposes (ie, to determine the cause of pain, to identify specific comorbidities) but also for clinical decision-making and research. Moreover, important domains of functioning that are affected by pain (eg, mood) need to be addressed both initially and over the course of treatment. “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 18 Welchen Nutzen hat ein Assessment von Schmerzen im Vergleich zu keinem Assessment für die ausgewählte Population?
Seite: 6
Zitat (Originalzitat): “A. Information collected from the Pain Assessment is to be used to formulate and implement a resident specific Pain Treatment Plan within the facility, (…)”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?
Seite: S208
Zitat (Originalzitat): “All patients with persistent pain that may affect physical function, psychosocial function, or other aspects of quality of life should undergo a comprehensive pain assessment, with the goal of identifying all potentially remediable factors (…) “
Evidence-Grad: III Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?
Seite: S210
Zitat (Originalzitat): “(…) unusual behavior in a patient with severe dementia should trigger assessment for pain as a potential cause “
Evidence-Grad: II Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?
Seite: 7 (2012)
Zitat (Originalzitat): “Because almost all patients in the LTC setting have predisposing factors for the development of chronic, noncancer pain, a high index of suspicion for the presence of pain is warranted. Every patient should be regularly and systematically evaluated for pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?
Seite: 5-6

Zitat (Originalzitat):
“PAIN ASSESSMENT
A. A complete Pain Assessment shall be done if the Pain Rating Scale score is above 0 in the circumstances listed in II-B, no. 1-5.
S. 5 II B:
B. A Pain Rating Scale shall be completed and documented, at a minimum, in the following circumstances:
1. as part of the Pain Screening upon admission
2. upon re-admission
3. upon day of planned discharge (send a copy with the resident)
4. when warranted by changes in the resident’s condition or treatment plan
5. self reporting of pain and/or evidence of behavioral cues indicative of the presence of pain
6. to identify and monitor the level of pain and/or the effectiveness of treatment modalities until the resident achieves consistent pain relief or pain control”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?

Seite: 9

Zitat (Originalzitat):
“If the older adult presents in moderate to severe acute pain (e.g., greater than four on a 0-10 numeric rating scale), the first priority is to complete an initial, rapid pain assessment and treat the pain (Jensen et al. 2001, Mendoza et al. 2004a, Paul et al. 2005, Serlin et al. 1995, Zelman et al. 2005). (S. in References: IIIa-b) “

Evidence-Grad: siehe Referenzen III-a – III-b
Empfehlungsstärken: nicht ausgewiesen

Referenzen:
Jensen, M.P., Smith, D.G., Ehde, D.M., Robinsin, L.R. (2001). Pain site and the effects of amputation pain: further clarification of the meaning of mild, moderate, and severe pain. Pain; 91 (3): S. 317-322. (III-a).
Mendoza, T.R., Chen, C., Brugger, A., Hubbard, R., Snabes, M., Palmer, S.N., Zhang, Q., Cleeland, C.S. (2004a). Lessons learned from a multiple-dose post-operative analgesic trial. Pain, 109 (1-2): S. 103-109. (III-b).
Paul, S.M., Zelman, D.C., Smith, M., Miaskowski, C. (2005). Categorizing the severity of cancer pain: further exploration of the establishment of cutpoints. Pain; 113 (1-2): S. 37-44. (III-a).
Serlin, R.C., Mendoza, T.R., Nakamura, Y., Edwards, K.R., Cleeland, C.S. (1995). When is cancer pain mild, moderate or severe? Grading pain severity by its interference with function. Pain; 61 (2): S. 277-284. (III-b).
Zelman, D.C., Dukes, E., Brandenburg, N., Bostrom, A., Gore, M. (2005). Identification of cutpoints for mild, moderate and severe pain due to diabetic peripheral neuropathy. Pain; 115 (1-2): S. 29-36. (III-a).

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 19 Welche Vortest-Wahrscheinlichkeit aus dem Screening spricht für die Durchführung eines Assessments?
Seite: 5 (2007)
Zitat (Originalzitat): “Unexpected intense pain, particularly if sudden or associated with altered vital signs such as hypotension, tachycardia, or fever, should be immediately evaluated.”
Evidence-Grad: nicht ausgewiesen Grade of Recommendation = C
Referenzen: American Pain Society (APS) (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS).

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: S207-S208
Zitat (Originalzitat): “A thorough initial assessment and an appropriate work-up are necessary to determine whether disease-modifying interventions could address the cause of a patient’s persistent pain.[26] Assessment should include evaluation of acute pain that might indicate new concurrent illness rather than exacerbation of persistent pain. (…)”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [26.] Ferrell, B.A. (2000). Pain. In: Osterweil, D., Brummel-Smith, K., Beck, J.C. (ed.) Comprehensive Geriatric Assessment. New York: McGraw Hill: S. 381-397.

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: S208
Zitat (Originalzitat): “Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (IIA)”
Evidence-Grad: II Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 12-13 (2012)
Zitat (Originalzitat): “Are the cause(s) of pain identified? If yes, proceed to Step 10 [Summarize the characteristics and causes of the patient's pain and assess the impact of pain on function and quality of life.]. If no, proceed to Step 6 [Perform further diagnostic testing, as indicated]. Pain is often categorized as one of the following two types, according to its presumed pathophysiology: nociceptive pain and neuropathic pain. Patients commonly have both types of pain. Several tools are available to distinguish nociceptive from neuropathic pain[34] (…) There are two types of nociceptive pain: somatic pain, (…) and visceral pain (…) Recognition of nociceptive pain can help to identify an acute condition demanding prompt treatment or a chronic condition, which can guide treatment to halt tissue damage[34]. (…) Neuropathic pain is caused by abnormal functioning of the peripheral or central nervous system (CNS). Neuropathic pain can result from degenerative disorders affecting neural tissues, direct compression, inflammation, ischemia, metabolic derangement, toxic exposure, or trauma. (…) Symptoms suggestive of a neuropathic pain process include heightened sensitivity to nonpainful stimuli, such as light touch; exaggerated sensitivity to mildly noxious stimuli; and pain that occurs despite the absence of objective physical evidence of injury or inflammation. Patients may describe their pain as burning, shooting, throbbing, or tingling. (…) .. There are also types of pain that do not fall into the two categories described above, such as existential pain. In elderly patients recently admitted to LTC, pain associated with the grief reaction resulting from the loss of independence or the recent loss of a spouse could

alter pain perception.[35,36]“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [34.] Arnstein, P. (2010). Assessment of nociceptive versus neuropathic pain in older adults. In: Try This: Best Practices in Nursing Care to Older Adults. Issue number SPI. The Hartford Institute for Geriatric Nursing, New York University; College of Nursing. Available at: http:// consultgerirn. org/uploads/File/trythis/try_this_sp1.pdf. Accessed 12/2/11. [35.] Das SS (1971). Grief and the imminent threat of non-being. Br J Psychiatry; 118: S. 467-468. [36.] Horowitz, M.J. (1986). Stress-response syndromes: A review of posttraumatic and adjustrnent disorders. Hosp Community Psychiatry; 37: S. 241-249.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 3
Zitat (Originalzitat): “Staff Observation Staff should formally observe and document both the known kinds of pain-related behaviours seen in people who are not cognitively impaired, as well as other behavioural and clinical changes that could indicate pain in people suffering from severe dementia. “
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 10
Zitat (Originalzitat): “Severity of Pain Once the presence of significant, persistent pain is identified, it is necessary to consider its nature and severity.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 4
Zitat (Originalzitat): “Where pain is present, all older people should have a detailed pain history taken and a clinical assessment of the multi-dimensional aspects of pain including: -a sensory dimension which describes the intensity and nature of pain -an affective/evaluative dimension which describes the emotional component of pain and how pain is perceived e.g. dangerous, exhausting, frustrating, frightening. -impact on life including physical, functional and psychosocial effects. “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 6
Zitat (Originalzitat): “Pain is a subjective, personal experience, really only known to the person who suffers. Pain is multidimensional. Dimensions include: i. a sensory dimension which describes the intensity and nature of pain (e.g. – crushing, sharp) ii. an affective / evaluative dimension which describes the emotional component of pain and how pain is perceived (e.g. dangerous, exhausting, frustrating frightening) iii. impact on life, including physical, functional, and psychosocial effects. “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 12
Zitat (Originalzitat): “Establishing the cause of pain A full medical history should be taken including a full history of the pain, its onset, its time course, radiation, aggravating and relieving factors, quality and associated symptoms. A full medication history should be taken, including ‘over the counter’, prescribed and complementary medicines. Past medical history should be detailed in view of co-morbidities which may be contributing to the pain. Physical examination should include: general physical examination, examination of painful region, musculoskeletal examination, neurological examination and cognitive status evaluation[45]”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [45.] Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Lynn,B.B., Chibnall, J., Craig, K.D., Ferrell, B., Ferrell, B., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S., Elizabeth, L., Katz, B., Keefe, F., Lieber, S., Lussier, D., Schmader, K., Tait, R., Weiner, D., Williams, J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons Clinical Journal of Pain; 23 (Supple): S. S1-S43.

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 15

Zitat (Originalzitat):
"Impact of pain
Pain has an impact on mood, sleep, mobility, function and quality of life [Evidence based statement]
Pain is associated with poor global function, depression, sleep problems and reduced life satisfaction in older people[56]. The classic patient profile of high pain, high impact and high mood disturbance (persistent pain syndrome) identified in younger to middle-aged adults may not be as common in older patients[57]. Older people with persistent pain are heterogeneous, some have less pain, less depression and high activity, others have high pain and high impact and others are mixed[58,59].
Mood should be assessed in all older people with pain. The Royal College of Physicians working party on assessment scales in older people recommended using the Hospital Anxiety and Depression Scale and the Geriatric Depression Scale[60, 61].
The pain-movement cycle is important in older adults with conditions such as arthritis; pain Interferes with physical functioning and acts as a barrier to use of diversional activities in pain management[62]. Pain related interference with moving about is more common in women than In men and increases with advancing age. The degree to which pain interferes with day to day function is influenced by comorbidities as well as intensity[63]. Mobility may need to be assessed particularly in response to interventions, a standardized measure being the Timed-Up-and-Go[64]."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[56.] Ross, M.M., Crook, J. (1998). Elderly recipients of home nursing services: pain, disability and functional competence. Journal of Advanced Nursing; 27: S. 1117-1126.
[57.] Corran, T.M., Farrell, M.J., Helme, R.D., Gibson, S.J. (1997). The classification of patients with persistent pain: Age as a contributing factor. Clinical Journal of Pain; 13 (3): S. 207-214.
[58.] Weiner, D.K., Rudy, T.E., Gaur, S. (2001). Are all older adults with persistent pain created equal? Preliminary evidence for a multiaxial taxonomy. Pain Research & Management; 6 (3): S. 133-141.
[59.] Hall-Lord, M.L., Larsson, G., Steen, B. (1999). Persistent pain and distress in older people: a cluster analysis. International Journal of Nursing Practice; 5: S. 78-85.
[60.] Zigmond, A.S., Snaith, R.P. (1983). The Hospital Anxiety and Depression Scale. Acta Psychiatrica Scandinavica; 67: S. 361-70.
[61.] Yeasavage, J. A., Brink, T. L., Rose, T. L., Lum, O. (1998). Development and validation of a geriatric depression screening scale: A preliminary report. Journal of Psychiatric Research; 17: S. 37-49.
[62.] Davis, G.C., Hiemenz, M.L., White, T.L. (2002). Barriers to managing persistent pain of older adults with arthritis. Journal of Nursing Scholarship; 34 (2): S. 121-31.
[63.] Scudds, R.J., Ostbye, T. (2002). Pain and pain-related interference with function in older Canadians: the Canadian study of health and aging. Disability and Rehabilitation; 23: S. 654-664.
[64.] Podsiadlo, D., Richardson, S. (1991). The timed "Up & Go": a test of basic functional mobility for frail elderly persons. Journal of the American Geriatrics Society; 39: S. 142–148.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 110
Zitat (Originalzitat): “Hadjistavropoulos et al.(2008) concluded that when assessing pain in patients with delirium and limited ability to communicate as a result of dementia, clinicians should place greater emphasis on items related uniquely to pain (e.g., protecting sore areas). “
Evidence-Grad und /oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Voyer, P., Sharpe, D., Verreault, R., Aubin, M. (2008). Assessing pain in dementia patients with comorbid delirium and depression. Pain Manag Nurs; 9: S. 48–54. doi:10.1016/j.pmn.2007.12.004.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 110
Zitat (Originalzitat): “Clinicians should always remember that the assessment of the pain patient will ideally be broad (i.e., not limited to the evaluation of pain intensity) and needs to incorporate results of physical examination, diagnostic information, consideration of psychological and environmental factors, and other related information.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S. S1-S43.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: S4
Zitat (Originalzitat): “A comprehensive assessment of pain must include the identification of relevant underlying physical pathologies and other conditions that may influence pain perception, report, and management. Assessment of functional limitations (eg, impairment in performance of basic, instrumental, and advanced activities of daily living (ADL), mobility, sleep, and appetite), psychosocial function (eg, mood, interpersonal interactions, beliefs about pain, fear of pain-related activity), and cognitive function (eg, dementia or delirium)[13–16] is necessary. As with younger adults,[17] information on functional limitations is extremely important for older persons because this information is used to guide therapy, establish reasonable and attainable goals, and to track outcomes.[18–20]”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [13.] Gibson, S.J., Katz, B., Corran, T.M. et al. (1994). Pain in older persons. Disabil Rehabil; 16: S. 127-139. [14.] Helme, R.D., Gibson, S.J. (1998). Measurement and management of pain in older people. Aust J Ageing; 17: S. 5–9. [15.] Weiner, D.K. (1994). Assessing persistent pain in older adults: practicalities and pitfalls. Analgesia; 4: S. 377–395. [16.] Weiner, D.K., Herr, K. (2002). Comprehensive Interdisciplinary Assessment and an Assessment Guide to Geriatric Neuropsychology. Mahwah, New Jersey: Lawrence Erlbaum Associates.

[17.] Von Korff, M., Wagner, E.H., Dworkin, S.F. et al. (1991). Chronic pain and use of ambulatory health care. Psychosom Med; 53: S. 61–79.
[18]Ersek, M., Turner, J.A., McCurry, S.M. et al. (2003). Efficacy of a selfmanagement group intervention for elderly persons with chronic pain. Clin J Pain; 19: S: 156–167.
[19.] Theiler, R., Bischoff, H.A., Good, M. et al. (2002). Rofecoxib improves quality of life in patients with hip or knee osteoarthritis. Swiss Med Wkly; 132: S. 566–573.
[20.] Weiner, D.K., Rudy, T.E., Glick, R.M. et al. (2002). Efficacy of percutaneous electrical nerve stimulation for the treatment of chronic low back pain in older adults. J Am Geriatr Soc; 51: S. 599–608.

Hadjistavropoulos et al._2007
Hadjistavropoulos, T., Herr, K. et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain 23(1): S. S1-S43.

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 6

Zitat (Originalzitat):
"The description of the current pain problem should include its site, spread, radiation, temporal pattern, quality descriptors, precipitating, exacerbating and relieving factors, and present and previous treatments (including medications, surgeries, and physical and psychologic treatment strategies). Because traumatic, inflammatory, and neoplastic conditions are most commonly associated with acute pain syndromes, and musculoskeletal and neurologic conditions are the most frequent causes of chronic pain in older adults, the history and physical examination should target these pathologie and systems.[4,16,22]
It is important to establish the time frame of the pain, whether it is acute or chronic, because diagnostic studies (eg, imaging studies) and treatment choices may vary. Relevant medical records should also be obtained and reviewed to corroborate the patient's reports."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[4.] American Geriatrics Society Panel on Persistent Pain in Older Persons. (2002). Clinical practice guidelines: the management of persistent pain in older persons. J Am Geriatr Soc; 50: S. S205–S224.
[16.] Weiner, D.K., Herr, K. (2002). Comprehensive Interdisciplinary Assessment and an Assessment Guide to Geriatric Neuropsychology. Mahwah, New Jersey: Lawrence Erlbaum Associates.
[22.] Weiner, D.K., Cayea, D. (2005). Low back pain and its contributors in older adults: a practical approach to evaluation and treatment. In: Gibson, S.J., Weiner, D.K. (ed.). Pain in Older Persons. Seattle, WA: IASP Press: S. 329–354.

Hadjistavropoulos et al._2007
Hadjistavropoulos, T., Herr, K. et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain; 23 (1): S. S1-43.

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 7

Zitat (Originalzitat):
"a good understanding of the patient's pain experience also requires an evaluation of the general physical, neurologic, musculoskeletal, and cognitive status of the patient."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 9
Zitat (Originalzitat): “Criteria for the assessment of pain, including, but not limited to: pain intensity or severity, pain character, pain frequency or pattern, or both; pain location, pain duration, precipitating factors, responses to treatment and the personal, cultural, spiritual, and/or ethnic beliefs that may impact an individual’s perception of pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 12
Zitat (Originalzitat): “Complete an initial, rapid pain assessment for patients presenting in acute pain of moderate to severe intensity or who appear to be in significant distress including the following: - Level of consciousness (LOC) including orientation to person/self, time and location. - Characteristics of the pain, including: Intensity of pain (…), Location, Duration of pain (onset and pattern), Quality. - Changes in vital signs, including: Respiratory status, Heart Rate, Blood pressure, Temperature, Absence of these autonomic responses does NOT mean absence of pain. (s. References : (IVa-Vb)”
Evidence-Grad:siehe Referenzen IVa-Vb Empfehlungsstärke: D
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6), S. S205-S224. (IV-a). APS. American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (Fifth ed.). Glenview, Illinois: American Pain Society (APS). (V-b). Kehlet, H. M. (1989). Surgical Stress: The role of pain and analgesia. British Journal of Anaesthesia, 63, S. 189-195. (IV). Pasero, C., Reed, B.A., McCaffery, M. (1999c). Pain in the elderly. In M. McCaffery & C. Pasero (Ed.), Pain: Clinical Manual for Nursing Practice 2nd ed.; S. 674-710. St. Louis, MO: Mosby. (V-a). VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite:15-18

Zitat (Originalzitat):

"Complete a **comprehensive assessment of the patient's** pain with the assistance of the patient and/or the family. In addition to rapid assessment factors, include the following:

- **Physical examination**. Focus on the reported location of pain and existence of pathological conditions known to be painful. (…) (Herr & Garand 2001; Kane et al. 2004; Kovach et al., 1999; McCaffery & Pasero, 1999).—C

Cognitive status. Assess cognitive status in older adults and screen for cognitive impairment. (…) (AGS, 2002; Maslow, 2004; Naylor et al., 2005; Souder & Beck, 2004).—C

- **Anxiety/fear and depression**. Assess for anxiety/fear and depression that may be experienced in anticipation of pain or as a consequence of pain. (…) (AGS, 2002; Casten et al., 1995; Ferrell, 2003; Herr & Garand, 2001;Turk et al., 1995).—C (…)
- **Functional status** (…) Assess the impact of pain on the patient's ability to perform activities of daily living, (e.g., bathing, dressing, eating, rising, sitting, walking) (AGS, 2002; Pasero et al., 1999c; Sengstaken & King, 1993).—C
  - Assess functional abilities (…), remembering to include sensory assessment. Obtain family assistance as needed.—D
  - Assess the impact of pain on and interference with quality of life activities (e.g., appetite, concentration, physical activity, relationships with others, emotions, sleep) (Mendoza et al., 2004b).—C (…)
- **Pain history** (current pain and past experiences with painful conditions)
  • Assess factors that alleviate or aggravate the older person's pain (AGS, 2002; McCaffery & Pasero, 1999; VHA/DoD, 2002).—D
  • Assess for a history of other chronic disorders. Chronic conditions (such as osteoarthritis, peripheral vascular disease, neuropathies) may cause pain and impact accurate assessment of acute pain (AGS, 2002; Donovan et al., 1987; VHA/DoD, 2002).—C
  • Assess sociocultural variables (e.g., ethnicity, acculturation, gender) that may influence pain behavior and expression. For example, the healthcare provider can work closely with patients and families to identify mutual goals with regard to pain management that take into account ethnicity-based values of being pain free (Green et al., 2003a; Green et al., 2003b; Green et al. 2004; Ibrahim et al. 2003; McCaffery & Pasero, 1999; Neill, 1993; Ng, 2002).—C
- **Differentiate procedural pain from chronic pain or pain due to complications of a procedure** (e.g., new pain, increased intensity of pain, pain not relieved by previously effective strategies) and direct treatment accordingly. Conducting a pain history before a procedure can help discriminate procedural from chronic pain. (…) (McCaffery & Pasero 1999; Morrison et al. 1998; VHA/DoD 2002).—C
- **Past pain experience and knowledge** (…)
  • Assess patient and family attitudes and beliefs regarding pain and analgesics and previous experiences with analgesics. Expectations regarding pain and stress during hospitalization; fear of addiction and analgesic side effects; fear of tolerance and side effects; and beliefs related to ageism, passivity of patient role, and stoicism. These beliefs and attitudes can interfere with the patient's report of pain and effective pain treatment (AGS, 2002; Brockopp et al., 1996; Ferrell et al., 1990; Ferrell et al., 1993; Hofland, 1992; VHA/DoD, 2002; Ward et al., 1998; Ward et al. 1993; Yates et al. 1995).—C (…)
- **Assess bowel and bladder functions** (e.g., usual frequency and quality of bowel movements, use of laxatives) (Hert & Huseboe, 1998).—D
- **Medication history**
  • Investigate medication use for chronic conditions that may interact or interfere with analgesic use (e.g., opioids, nonsteroidal anti-inflammatory drugs [NSAIDs],

antidepressants, antipsychotics, hypnotics, sedatives) (AGS, 2002; Ashraf et al., 2004).—D
• Investigate allergies to analgesics. Analgesic side effects are often misinterpreted as allergic reactions, e.g., pruritus and nausea associated with opioids are usually due to mechanisms other than allergy (McCaffery & Pasero, 1999).—E
• Ask about alcohol consumption. Alcohol consumption is important information as it can impact analgesia selection. Be careful to ask in a nonjudgmental manner (e.g., How much alcohol do you drink? Do you drink two six-packs of beer over the course of a day?) (AGS, 2002; Antai-Otong, 1995; Martin et al., 2002; Pasero et al., 1999c).—C
(…)

2) **Involve the family** in all aspects of assessment and planning for pain management. Provide opportunity for individualized patient/family and nurse interaction (AGS 2002; Ferrell et al., 1991; Sengstaken & King, 1993; VHA/DoD, 2002; Weiner et al., 1999; Werner et al., 1998).—C"

Evidence-Grad: siehe Referenzen IIa-Vb
Empfehlungsstärke: C - E

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Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 18

Zitat (Originalzitat):
"This section regarding the special pain assessment needs of cognitively impaired older adults should be used to supplement the previous section on pain assessment. In principle, the following hierarchy of importance of basic measures of pain presence and intensity should be considered when assessing pain:
1. Patient's self-report using a pain rating scale (e.g., VDS, Faces, NRS 0-10)
2. Pathological conditions or procedures that usually cause pain
3. Behaviors (e.g., facial expressions, crying)
4. Report of pain from a family member or others close to the patient
5. Physiological measures such as blood pressure or heart rate are the least sensitive indicators of pain (McCaffery & Pasero, 1999).—E
Assess cognitive status of older adult patients. Screen for cognitive impairment using reliable tools. Differentiate between delirium and dementia as managing pain and other aspects of care may vary depending on condition."

Evidence-Grad: siehe Referenzen Vb
Emfehlungsstärke: E

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Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 19

Zitat (Originalzitat):
"For older adults with cognitive impairment unable to report pain, assess for the presence of factors that cause pain. Whenever an older adult with cognitive impairment shows a change in mental status, pain should be considered a potential etiology. Potential sources of pain include distended bladder, incision, infection, inflammation, fracture, positioning, UTI, and constipation.(…) (Closs & Briggs, 2002; Kovach et al.,1999; Miller et al., 1996; Pasero et al., 1999c; VHA/DoD 2002).—B"

Evidence-Grad: siehe Referenzen IIIa-Va
Empfehlungsstärke: B

Referenzen:
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VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense.(IV-b).

Horgas et al_2008 Horgas A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 3
Zitat (Originalzitat): “Older adults with cognitive impairment experience pain but are often unable to verbalize it (Smith, 2005 [Level I]).”
Evidence-Grad: [Level I]. Empfehlungsstärke: nicht ausgewiesen
Referenzen: Smith M. (2005). Pain assessment in nonverbal older adults with advanced dementia. Perspect Psychiatr Care; 41 (3): S. 99-113.

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 6-7
Zitat (Originalzitat): “Assessment: Pain and Functioning • Ask about pain presence The initial step in assessing for persistent pain is to ask about the presence of pain. If pain presence is confirmed, then the nurse should further assess for criteria associated with the definition of persistent pain provided by Bonica (1990), that of lasting 1 month longer than expected, or associated with a chronic constant pain producing condition, or characterized by recurrent intervals over time. In addition, obtain information about the intensity and location of pain as well as any precipitating and relieving factors. (…) Some older adults may identify with words other than pain, such as discomfort, hurt, or ache (AGS, 2002). When using this guideline, the nurse should consistently use the same word throughout the process. • Identify the underlying cause and associated factors. It is important to identify the underlying cause of the pain because management is more successful if directed toward the specific causative condition (AGS, 2002; Ferrell, 2000. Evidence Grade = C). Thus, a thorough review of the medical history, physical examination, and any pertinent laboratory studies or diagnostic tests is important in determining the cause (AGS, 2002. Evidence Grade = D). In addition, assess for other factors such as attitudes and beliefs about pain and its treatment that could affect pain reporting and management. For example, patients may believe that pain is a normal part of aging, fear that pain means disease progression, and fear medication addiction or adverse side effects (AGS, 2002; Green,Wheeler, & LaPorte 2003; Kovach, Griffie, Muchka, Noonan, & Weissman, 2000. Evidence Grade = C). • Assess the impact of pain on physical functioning Older adults with persistent pain commonly experience an increase in pain intensity with movement and, as a result, will limit the activities or movements that exacerbate the pain (e.g., stair climbing or walking) (Davis, Hiemenz, & White, 2002; Duong, Kerns, Towle, & Reid, 2005. Evidence Grade = C). (…) • Assess the impact of pain on psychosocial functioning In addition to pain intensity, the assessment of persistent pain should also include information about its interference with psychosocial functioning. Pain has been shown to be associated with depression, distress, and a decline in social activities (Baker 2005; Haythornthwaite et al., 2003; Mossey & Gallagher, 2004; Tsai, 2005. Evidence Grade = C). “
Evidence-Grad und/oder Empfehlungsstärke: C - D

Referenzen:
American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. 1-20. (N)
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Green, C.R., Wheeler, J.R., LaPorte, F. (2003). Clinical decision making in pain management: Contributions of physician and patient characteristics to variations in practice. The Journal of Pain; 4: S. 29-39. (R)
Haythornthwaite, J.A., Clark, M.R., Pappagallo, M., Raja, S. (2003). Pain coping strategies play a role in post-herpetic neuralgia. Pain; 106: S. 453-460. (R)
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RNAO_2002_2007
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Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 3 (2007) & 21 (2002)

Zitat (Originalzitat):
"S. 3 (2007): A systematic, validated pain assessment tool is selected to assess the following basic parameters of pain: Grade of Recommendation = C
■ location of pain;
■ effect of pain on function and activities of daily living (i.e., work, interference with usual activities, etc.);
■ level of pain at rest and during activity;
■ medication usage and adverse effects;
■ provoking or precipitating factors;
■ quality of pain (what words does the person use to describe pain? - aching, throbbing);
■ radiation of pain (does the pain extend from the site?);
■ severity of pain (intensity, 0-10 scale), pain related symptoms; and timing (occasional, intermittent, constant). (…)
Bird 2003; Brown 2004; Kleiber et al. 2001; Van Dijk et al. 2002; Voepel-Lewis et al. 2002 "

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: C

Referenzen:
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90.
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
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Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 4 (2007) & 21 (2002)

Zitat (Originalzitat):
“S. 4 (2007): Pain assessment in patient populations who are unable to give self-report (non-communicative) may include behavioural indicators using standardized measures and physiological indicators where appropriate. Grade of Recommendation = C (…)
Bird 2003; Brown 2004; Cavender et al. 2004; Feldt 2000; Kaasalahen & Cook 2003; Kleiber et al. 2001; Krulewitch et al. 2000; Malviya et al. 2006; Van Dijk et al. 2001; Van Dijk et al. 2002; Voepel-Lewis et al. 2002 (...)”

“S. 4 (2007): The following parameters are part of a comprehensive pain assessment:
■ physical examination, relevant laboratory and diagnostic data;
■ effect and understanding of current illness;
■ history of pain;
■ meaning of pain and distress caused by the pain (current and previous);
■ coping responses to stress and pain;
■ effects on activities of daily living;
■ psychosocial and spiritual effects;
■ psychological - social variables (anxiety, depression);
■ situational factors – culture, language, ethnic factors, economic effects of pain and treatment;
■ person’s preferences and expectations/beliefs/myths about pain management methods; and
■ person’s preferences and response to receiving information related to his/her condition and pain.
Grade of Recommendation = C
(…)”
Alamo et al. 2002; APS 2005; Bird 2003; Brown 2004; ICSI 2006; Kleiber et al. 2001; Krulewitch 2000; Van Dijk et al. 2001; Van Dijk et al. 2002

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: C

Referenzen:
Alamo, M.M., Moral, R.R., de Torres, L. (2002). Evaluation of a patient-centred approach in generalized musculoskeletal chronic pain/fibromyalgia patients in primary care. Patient Education and Counseling; 48 (1): S. 23-31.
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Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90.
Institute for Clinical Systems Improvement (ICSI) (2006). Assessment and management of acute pain. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI).
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
Krulewitch, H., London, M., Skakel, V., Lundstedt, G., Ghomason, H. Bummel-Smith, K. (2000). Assessment of pain in cognitively impaired older adults: A comparison of pain assessment tools and their use by nonprofessional caregivers. Journal of the American Gertiatric Society; 48 (12): S. 1607 1611.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
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Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 21 (2002)

Zitat (Originalzitat):
"S. 21 (2007): **Appendix C – Sample Questions for Baseline Assessment of Pain**
There are several mnemonics noted in the literature that can be used to structure a baseline assessment of pain. (…)
SAMPLE 1: PAINED
Place – Location of the pain (could be multiple sites).
Amount – Refers to pain intensity (10 point scale), onset, duration, pattern of pain.
Intensifiers – What makes the pain worse? (i.e., activity, position, time of day, stress, etc.).
Nullifiers – What makes the pain better? (i.e., type and amount of medication, non-pharmacological methods).
Effects – Effect of pain on quality of life (i.e., functional status, sleep, appetite, social interactions); adverse effects of analgesics.
Descriptors – Description of the quality of the pain (i.e., aching, throbbing, burning, stabbing, pressure, etc.).
SAMPLE 2: OLDCART
Onset – When did the pain start?
Location – Where is your pain? (Could be multiple sites).
Duration – How long does your pain last? Is it persistent or periodic?
Characteristics – What does it feel like? Is it burning, sharp, shooting, throbbing, etc?
Aggravating Factors – What makes your pain worse (e.g., walking, moving, breathing, turning, chewing).
Relieving Factors – What makes your pain better? Ask about any non-pharmacological approaches.
Treatment – What medications work for you? Do you have side effects from your medications?!

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Alamo, M.M., Moral, R.R., de Torres, L. (2002). Evaluation of a patient-centred approach in generalized musculoskeletal chronic pain/fibromyalgia patients in primary care. Patient Education and Counseling; 48 (1): S. 23-31.
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Feldt, K. (2000). The checklist of non-verbal pain indicators (CNPI). Pain Management Nursing; 1 (1): S. 13-21.
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Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research; 35 (4): S. 58-71.
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
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Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 40 (2007)

Zitat (Originalzitat):
"Accurate assessment and diagnosis of the type of pain, its severity, and its effect on the person are necessary to plan appropriate interventions or treatments, and are an integral part of overall clinical assessment (SIGN, 2000). Pain should be assessed and documented on a regular basis according to type and intensity."

Evidence-Grad und/oder Empfehlungsstärke:nicht ausgewiesen

Referenzen:
Scottish Intercollegiate Guidelines Network (SIGN) (2000). Control of pain in patients with cancer. SIGN.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 7-8 (Teil 1)
Zitat (Originalzitat): “Vgl. Overzicht kenmerkend(e) pijnbeleving en pijngedrag bij kwetsbare ouderen met specifieke aandoeningen”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: Verweis auf: deel 2, paragraaf 2.2.4 / Seite 17 -18
Ggf. weitere Bemerkungen Die Original verenso Leitlinie fügt auf S7-8 ein Übersicht ein über Erkrankungen (Ältere Menschen mit physische Erkrankungen; M. Parkinson (…) , Multiple sclerose (…); ; M. Huntington; CVA; M. Alzheimer; Vaskuläre Demenz; Lewy Body Demenz; Frontotemporale Demenz; Semantsiche Demenz. Des weiteren werden pro Krankheitsbild die Schmerzintensitäten, sensorische Aspekte und Schmerzverhalten beschrieben

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?
Seite: 11 (Teil I) & 45 (Teil II)
Zitat (Originalzitat): “Meetinstrumenten voor een multidimensionale beoordeling van pijn (zie deel 2, paragraaf 3.3.4) 3r) Bij alle kwetsbare ouderen met pijn dient, voor zover het cognitief/communicatief functioneren van de kwetsbare oudere met pijn dit toelaat, een klinische beoordeling van de multidimensionale aspecten van pijn plaats te vinden: – de zintuiglijke dimensie betreft ernst en aard van de pijn; – de affectieve/evaluatieve dimensie betreft de emotionele component van pijn en de wijze waarop pijn wordt waargenomen (bijvoorbeeld als gevaarlijk, uitputtend, beangstigend); – de invloed van pijn op het dagelijks functioneren (fysiek, functioneren en psychosociale effecten); – de invloed van leef- en (i)ADLomstandigheden, juiste inzet van hulpmiddelen en over- of onderprikkeling.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:

Auret, K.A., Toye, C., Goucke, R., Kristjanson, L.J., Bruce, D., Schug, S. (2008). Development and testing of a modified version of the brief pain inventory for use in residential aged care facilities. J Am Geri-atr Soc.; 56 (2): S. 301-6.
Chaudakshetrin, P. (2009). Validation of the Thai Version of Brief Pain Inventory (BPI-T) in cancer patiënts. J Med Assoc Thai; 92 (1): S. 34-40.
Dicle, A., Karayurt, O., Dirimese, E. (2009). Validation of the Turkish version of the Brief Pain Inventory in surgery patiënts. Pain Manag Nurs; 10 (2): S. 107- 113.e2.
Ferrell BA, Stein WM, Beck JC. (2000) The geriatric pain measure: validity, reliability and factor analysis. Journal of the American Geriatrics Society;48:1669-73.
Fisher SE, Burgio LD, Thorn BE, Hardin JM. (2006) Obtaining Self-Report Data From Cognitively Impaired Elders: Methodological Issues and Clinical Implications for Nursing Home Pain Assessment The Gerontologist; 46:81-88.
Gagliese L, Melzack R. (1997) Age differences in the quality of chronic pain: a preliminary study. Pain Res Management; 2: 157-62.
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Gjeilo, K.H., Stenseth, R., Wahba, A., Lydersen, S., Klepstad, P. (2007). Validation of the brief pain inventory in patiënts six months after cardiac surgery. J Pain Symptom Manage; 34 (6): S. 648-56.
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Melzack R. (1975) The McGill Pain Questionnaire: major properties and scoring methods. Pain; 1: 277-299.
Melzack R. (1987) The short-form McGill Pain Questionnaire. Pain; 30: 191-7
Oldenmenger, W.H., Stronks, D.L., Terwiel, C.T.M., Verhage, S., Gootjes, J.R.G., Klomp, M., De Wit, R. (2005). Naar een landelijke, verpleegkundige uniforme pijnanamnese. Nederlands tijdschrift voor Pijn en Pijnbestrijding; 25 (25): S. 6-12.
Poundja, J., Fikretoglu, D., Guay, S., Brunet, A. (2007). Validation of the French version of the brief pain inventory in Canadian veterans suffering from traumatic stress. J Pain Symptom Manage.; 33 (6): S. 720-6.

Verenso_2011

Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 20: Welche Informationen sind für den Umgang mit Schmerzen notwendig?

Seite: 35 (Teil II)

Zitat (Originalzitat):

“Pijn heeft invloed op stemming, slaap-waakritme, mobiliteit, functioneren, kwaliteit van leven en vice versa. (...) “

“3 j) Overweeg een systematische beoordeling van stemming, slaap-waakritme, mobiliteit en functioneren, met een hiervoor gevalideerd instrument, afgestemd op het cognitief/communicatief functioneren van de kwetsbare oudere.”

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:

Nicht ausgewiesen

Frage 21: Wie können diese Informationen gewonnen werden?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: S208
Zitat (Originalzitat): “A verbally administered 0–10 scale is a good first choice for measuring pain intensity in most older persons. (…) However, a substantial portion of older adults (with and without cognitive impairment) may have difficulty responding to this scale. Other verbal descriptor scales, pain thermometers, and faces pain scales also have accepted validity in this population and may be more reliable in those who have difficulty with the verbally administered 0–10 scale. [26] Thus it is important to utilize a scale that is appropriate for the individual and document and use the same tool with each assessment[26] (…). “ “Sensory and cognitive impairment, common among frail older people, make communication more difficult; fortunately, pain can be assessed accurately in most patients by the use of techniques adapted for the individual’s handicaps.[31,42] Assessment and treatment strategies need to be sensitive to culture and ethnicity, as well as the values and beliefs of individual patients and families. Information from family and other caregivers should also be included in the assessment.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [26.] Ferrell, B.A. (2000). Pain. In: Osterweil, D., Brummel-Smith, K., Beck, J.C., (ed.) Comprehensive. Geriatric Assessment. New York: McGraw Hill: S. 381- 397. [31.] Herr, K., Mobily, P.R., Kohout, F.J. et al. (1998). Evaluation of the Faces Pain Scale for use with the elderly. Clin J Pain; 14: S. 29-38. [42.] Gagliese, L., Melzack, R. (1997). Age differences in the quality of chronic pain: a preliminary study. Pain Res Manage; 2: S. 157-162.

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: S208
Zitat (Originalzitat): “All patients with persistent pain that may affect physical function, psychosocial function, or other aspects of quality of life should undergo a comprehensive pain assessment, with the goal of identifying all potentially remediable factors. (See Table 2 for sample pain interview questions.)” “Table 2. Sample Questions in a Pain Interview 1. How strong is your pain right now? What was the wors/average pain over past week? 2. How many days over the past week have you been unable to do what you would like to do because of your pain? 3. Over the past week, how often has pain interfered with your ability to take care of your self, for example with bathing, eating, dressing, and going to the toilet? 4. Over the past week, how often has pain interfered with your ability to take care of your home-related chores, such as going grocery, shopping, praparing meals, paying bills, and driving? 5. How often do you participate in pleasurable activities such as hobbies, socializing with friends, travel? Over the past week, how often has pain interfered with these activities? 6. How often do you do some type of exercise? Over the past week, how often has pain interfered with your ability to exercise? 7. How often does pain interfere with your ability to think clearly?

8. How often does pain interfere with your appetite? Have you lost weight?
9. How often does pain interfere with your sleep? How often over the past week?
10.Has pain interfered with your energy, mood, personality, or relationships with other people?
11. Over the past week, how often have you taken pain medication?
12. How would you rate your health at the present time?

Adapted with permission from Weiner D, Herr K, Rudy T (ed.). Persistent Pain in Older Adults: An interdisciplinary Guide for Treatment. New York: Springer (in press).

Assessment should focus on recording a sequence of events that led to the present pain complaint (…) (IIIB)"

"A. History

1. Initial evaluation of present pain complaint should include pain characteristics, such as intensity, character, frequency (or pattern, or both), location, duration, and precipitating and relieving factors. (IIIA)
2. Initial evaluation should include a description of pain in relation to impairments in physical and social function (e.g., activities of daily living [ADLs], instrumental activities of daily living [IADLs], sleep, appetite, energy, exercise, mood, cognitive function, interpersonal and intimacy issues, social and leisure activities, and overall quality of life). (IIA)
3. Initial evaluation should include a thorough analgesic history, including current and previously used prescription medications, over-thecounter medications, complementary or alternative remedies, and alcohol use or abuse.The effectiveness and any side effects of current and previously used medications should be recorded. (IIIB)
4. The patient's attitudes and beliefs regarding pain and its management, as well as knowledge of pain management strategies, should be assessed. (IIB)
5. Effectiveness of past pain-relieving treatments (both traditional and complementary or alternative) should be evaluated. (IIIB)
6. The patient's satisfaction with current pain treatment or health should be determined and concerns should be identified. (IIIB)"

Evidence-Grad: II - III
Empfehlungsstärke: A -B

Referenzen: nicht ausgewiesen

AGS 2002
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: S208-S210

Zitat (Originalzitat):

"1. Physical examination should include careful examination of the site of reported pain, common sites for pain referral, and common sites of pain in older adults. (IIIA)
2. Physical examination should focus on the musculoskeletal system (e.g., myofascial pain, fibromyalgia, inflammation, deformity, posture, leg length discrepancy). Practitioners skilled in musculoskeletal examination should be considered for consultation (e.g., physical therapy, occupational therapy, and physiatry). (IIIA)
3. Physical examination should focus on the neurologic system (e.g., search for weakness, hyperalgesia, hyperpathia, allodynia, numbness, paresthesia, other neurologic impairments).(IIIA)
4. Initial assessment should include observationof physical function (e.g., measures of ADLs,performance measures such as range of motion,get-up-and-go test, or others). (IIA)"

Evidence-Grad: II - III
Empfehlungsstärke: A

Referenzen: nicht ausgewiesen

AGS 2002
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: S210

Zitat (Originalzitat):
"C. Comprehensive pain assessment should include results of pertinent laboratory and other diagnostic tests. (IIIB)
D. Initial assessment should include evaluation of psychologic function, including mood (e.g., depression, anxiety), self-efficacy, pain coping skills, helplessness, and pain-related fears. (IIA)
E. Initial assessment should include evaluation of social support, caregivers, family relationships, work history, cultural environment, spirituality, and healthcare accessibility. (IIB)
F. Cognitive function should be evaluated for new or worsening confusion. (IIA)"

Evidence-Grad: II - III
Empfehlungsstärke: A - B

Referenzen: nicht ausgewiesen

AGS 2002
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: S210

Zitat (Originalzitat):
"G. For the older adult who is cognitively intact or who has mild to moderate dementia, the practitioner should attempt to assess pain by directly querying the patient. (IIA)
1. Quantitative estimates of pain based on clinical impressions or surrogate reports should not be used as a substitute for self-report unless the patient is unable to reliably communicate his or her pain. (IIA)
2. A variety of terms synonymous with pain should be used to screen older patients (e.g., burning, discomfort, aching, soreness, heaviness, tightness). (IIIA)
3. A quantitative assessment of pain should be recorded by the use of a standard pain scale that is sensitive to cognitive, language, and sensory impairments (e.g., scales adapted for visual, hearing, foreign language, or other handicaps common in elderly persons). (…) (IIA)
(…) S. 210
5. Elderly persons with limited attention span or impaired cognition should receive repeated instructions and be given adequate time to respond. Assessment may be done in several steps; it may require assistance from family or caregivers, and planning in advance of the visit. (IIIB)
6. Patients should be queried about symptoms and signs that may indicate pain, including recent changes in activities and functional status; they should also be observed for verbal and nonverbal pain-related behaviors and changes in normal functioning. (See Table 3 for some common pain indicators.) (IIA) "
"Table 3. Common Pain Behaviors in Cognitively Impaired Elderly Persons
Facial expressions
Slight frown; said, frightened face
Grimacing, wrinkled forehead, closed or tightened eyes
Any distorted expression
Rapid blinking
Verbalizations, vocalizations
Sighing, moaning, groaning
Grunting, chanting, calling out
Noisy brathing
Asking for help
Verbally abusive
Body movements
Rigid, tense body posture, guarding

Fidgeting Increased pacing, rocking Restricted movement Gait or mobility changes **Changes in interpersonal interactions** Aggressive, combative, resisting care Decreased social interactions Socially inappropriate, disruptive Withdrawn **Changes in activity patters or routines** Refusing food, appetite change Increase in rest periods Sleep, rest pattern changes Sudden cassation of common routines Increased wandering **Mental status changes** Crying or tears Increased confusion Irritability or distress Note: Some patients demonstrate little or no specific behavior or associated with severve pain.Source: AGS Panel on Persistent Pain in Older Persons 7. Patients can also be asked about their worst pain experience over the past week. (IIB) 8. With mild to moderate cognitive impairment, assessment questions should be framed in the present tense because patients are likely to have impaired recall. (IIB) “
Evidence-Grad: II - III Empfehlungsstärke: A - B
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society; 50: S. 205-224.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: S210
Zitat (Originalzitat): “IV. For the older adult with moderate to sever severe dementia or who is nonverbal, the practitioner should attempt to assess pain via direct observation or history from caregivers. (See Figure 2 for an algorithm for assessing pain in cognitively impaired persons.) A. Patients should be observed for evidence of painrelated behaviors during movement (e.g., walking, morning care, transfers). (IIA) B. Unusual behavior in a patient with severe dementia should trigger assessment for pain as a potential cause. (IIA)“ Die Leitlinie schlägt einen Algorithmus zur Schmerzerkennung vor (vgl. dort S. 212)
Evidence-Grad: II Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 3 (2012)
Zitat (Originalzitat): “Pain is frequently undertreated in cognitively impaired patients[10]. Contrary to a commonly held belief, such patients are often able to report feeling pain. For exarnple, one study showed that patients with various degrees of dementia could provide consistent, reliable self-report data about pain when given appropriate time and assistance to do so[11]”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [10] Reynolds, K.S., Hanson, L.C., DeVellis, R.P. et al. (2008). Disparities in pain management between cognitively intact and cognitively inlpaired nursing home residents. J Pain Symptom Manage; 35: S. 388-396. [11] Fisher, S.E., Burgio, L.D., Thorn, B.E., Hardin, J.M. (2006). Obtaining self-report data from cognitively impaired elders: Methodological issues and clinical implications for nursing home pain assessment. Gerontologist; 46: S. 81-88.

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 8 (2012)
Zitat (Originalzitat): “The best indicator of the pain experience is the patient' s own report, which must include an assessment of pain intensity and the effect of pain on activities of daily living[2]. Asking the patient about pain directly rather than relying on the patient to volunteer the information improves the detection of pain.[16] It is helpful to ask the question in different ways, (…)”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [2.] American Geriatries Society (AGS) (2009). Panel on the Pharmaeologieal Management of Persistent Pain in Older Persons. Pharmaeological management of persistent pain in older persons. J Am Geriatr Soe; 57: S. 1331-1346. [16.] CMS. Minimum Data Set, Version 3.0 (MDS 3.0). Baltimore, MD: Centers for Medicare and Medicaid Services. Available at: https:/ / www.cms.gov/nursinghomequalityinits/. Accessed 12/2/11.

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 8-9 (2012)
Zitat (Originalzitat): S. 9: “Observe the patient for nonspecific signs and symptoms that suggest pain (Table 3). (…)” “TABLE 3. Nonspecific Signs and Symptoms That May Suggest the Presence of Pain - Bracing, guarding, rubbing - Change in behavior - Change in gait - Decreased activity levels

- Eating or sleeping poorly
- Fidgeting, increasing er recurring restlessness
- Frowning, grimacing, fearful facial expressions, grinding of teeth
- loss of function
- Resisting cerfain movements during care
- Sighing, groaning, crying, breathing heavily
- Striking out, increasing or recurring agitation

Sources: Hurley et al. 1992[22] ; Horgas and Miller 2008[23] ; Herr et al. 2009[24] ; Ingrid and Marsella 2008[25] (…)"

S. 8:

"For example, resistance to movement, a limitation in the range of motion of an extremity, or an alteration in gait or posture may indicate a change in the patient's comfort level with previously routine movements and activities. (…) It is also often helpful to ask family members how the patient historically has expressed pain or discomfort."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[22.] Hurley, A.C., Volicer, B.J., Hanrahan, P.A. et al (1992). Assessment of discornfort in advanced Alzheimer patients. Res Nurs Health; 15: S. 369-377.

[23.] Horgas, A., Miller, L. (2008). Pain assessment in people with dementia. Am J Nurs; 108: S. 62-70.

[24.] Herr, K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older·adults with dementia: a state-ot-the-science review. J Pain Symptom Manage; 31: S. 170-192.

[25.] Ingrid, B., Marsella, A. (2008). Factors influencing exercise participation by dients in long-term care. Perspectives; 32: S. 5-11.

AMDA_2009_2012

American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).

Summary 2009 & Volltext 2012

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 9 (2012)

Zitat (Originalzitat):

"Conduct an initial review to determine whether the characteristics and causes of the patient' s pain have been identified. Better pain control is achieved when a specific pain source is identified and treated, as opposed to the treatment of generalized pain. Appropriate members of the interdisciplinary team should

• Review the patient' s known diagnoses or conditions and identify possible additional factors that may be causing or contributing to pain;
• Ask the patient to rate the intensity of his or her pain, using either a numerical score or a verbal or visual descriptor that is appropriate for and preferred by the patient;
• Ask about key characteristics of the pain (e.g., duration, frequency, location, onset, pattern, radiation) and for words that describe its qualities (e.g., aching, burning, throbbing);
• Use a specialized assessment tool for patients who cannot answer questions;
• Note the factors that make the pain better or worse;
• Identify recent exacerbations of chronic pain (is there a pattern?);
• Assess or evaluate how pain is affecting the patient' s mood and its impact on activities of daily living (ADLs), sleep, and selected quality-of-life measures (e.g., participation in hobbies, visiting with family); "

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 10 (2012)
Zitat (Originalzitat): “Many conditions common to LTC patients can cause pain. Identify those conditions in a timely manner, assess them appropriately, and plan effective pain management wherever possible. Pain management is most successful when the underlying causes of pain can be identified and treated.[7] Although staff and practitioner assessments and evaluations should incorporate a patient’s self-report of pain, additional direct examination is important. Effective diagnosis depends on the use of accurate historical and clinical information along with physical evidence derived from an appropriate examination.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [7.] AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. J Am Geriatr Soc; 50: S. S205-S224.

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 11-12 (2012)
Zitat (Originalzitat): “Perform a pertinent history and physical examination. (…). Pay particular attention to body regions and organ systems that appear to be related to or contributing to the patient’s pain. (…) Information about conditions relevant to current pain symptoms may be found in the patient' s hospital discharge summary. The medical history should include the following: - The patient' s existing diagnoses and conditions that may be causing or contributing to pain; - Information from the patient's family or the interdisciplinary team that may suggest other diagnoses and conditions. (…) - The patient' s current medications.(…) with particular attention to medications that may cause or exacerbate painful conditions. (…) - Prior diagnostic evaluations, interventions, and treatments for pain; and - Beneficial and adverse effects of medications previously used to treat pain. Regardless of whether the practitioner has seen the patient or when the practitioner will see the patient next, nursing staff should perform a sufficiently detailed evaluation to characterize the pain, which may include • Assessing the skin for painful conditions, including breakdown, rash, or inflammation; • Checking for redness, warmth, or pain with movement in a painful joint; • Listening for the presence of bowel sounds; • Palpating a tender abdomen or other painful areas; • Seeking evidence of possible bladder distention; and • Checking for fecal impaction.“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Summary 2009 & Volltext 2012

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 11 (2012)

Zitat (Originalzitat):
"Accurate diagnosis presents special challenges in patients who have cognitive or communication impairments. In such patients, it may be particularly difficult to determine whether signs and symptoms such as those listed in Table 3 are caused by pain or by another problem, such as a medication side effect, a fluid or electrolyte imbalance, or delirium related to causes other than pain. To the extent possible, rule out specific medical conditions before concluding that nonspecific symptoms are related to pain."
[Anm: Table 3 s. oben]

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

AMDA_2009_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
SUMMARY 2009 & Volltext 2012

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 13 (2012)

Zitat (Originalzitat):
"Obtain additional evaluation or consultation as necessary. Consider consultation when the diagnoses or conditions contributing to pain are still not clear after completion of Steps 4 to 7
[4. Perform a pertinent history and physical examination]
[5. Are the cause(s) of pain identified?]
[6. Perform further diagnostic testing, as indicated]
[7. Have the probable cause(s) of pain been identified?]
or if special skills are required for definitive treatment. (…)
Additionally, a neurologist, orthopedist, physiatrist, or specialist in pain or palliative medicine may provide insights into the causes of pain and suggest treatment options."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 2

Zitat (Originalzitat):
"Residents Able to Report Pain
The most accurate and reliable evidence of the existence of pain and its intensity is an individual's report.[13] Residents with no dementia, mild to moderate dementia, and with whom verbal communication is feasible despite other communicative difficulties, should be asked about their pain very carefully (Table 2).
Table 2
ASKING COMMUNICATIVE RESIDENTS ABOUT THEIR PAIN

- Staff taking a general medical history or pain history should sit down with the resident, make eye contact and demonstrate a willingness to discuss wether the resident has any pain
- Staff should allow sufficient time for the resident to process the question and formulate a response.[14]
- The resident should be asked about pain in a broad and open-ended way, using at least two questions, phrased in different ways, such as

1. Does it hurt anywhere?[3]
2. Do you have any aching or soreness?[3]
3. Do you have any ache, pain or discomfort?[4]
4. Is you pain a big problem, a medium-sized problem, or a small problem?[4]
5. From time to time, most of us have had pain, such as minor headaches, sprains and toothaches. Have you had pain other than these everyday kind of pain during the past 24 hours?[15]"

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[13.] American Geriatrics Society panel guidelines on persistentpain in older persons (2002). J Am Geriatr Soc; 50: S. S205-S224.
[14.] Herr, K.A., Garand, L. (2001). Assessment and measurement of pain in older adults. In Ferrell B (ed). Pain management in the elderly. Clinics in geriatric medicine. WB Saunders Company.
[3.] American Health Care Association and Medical Directors Association © (1999). Clinical practice guideline: chronic pain management in the long-term care setting.
[4.] McClean, W.J., Higginbotham, N.H. (2002). Prevalence of pain among nursing home residents in rural New South Wales. Med J; 177: S. 17-20.
[15.] Cleeland, C.S. (1989). Measurement of pain by subjective report. In Chapman, C.R., Loeser, J.D. (ed.). Issues in pain measurement. New York: Raven Press.

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 3

Zitat (Originalzitat):
"Residents Unable to Report Pain
Although more studies are needed in the complex area of care that involves residents who are unable to report pain, mostly due to dementia or other causes such as dysphasia, dysarthria or delirium, current published evidence and expert opinion support the use of two structured procedures: Staff Observation and an Informant Report.
With both procedures, it is important to record if the identified pain behaviour occurs at rest (and over what time) or only in relation to a certain activity (for example, being turned) or in conjunction with other activities (for example, moving a certain part during dressing or bathing)."

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 3

Zitat (Originalzitat):
"- In the many borderline cases that will arise, where some pain report is present but is difficult to obtain consistently, the verbal report information should be supported with the observational procedures described below.
- Some residents with moderate to severe impairment will be best managed, at least initially, by simultaneous institution of both verbal and observational sets of identification procedures."

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 4

Zitat (Originalzitat):
“Informant Report
This involves obtaining and documenting a report from people familiar with the resident including family members, carers, nurses, personal care assistants or other informant, surrogate or proxy who knows the resident well[16].”

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[16.] Krulewitch, H., London, M.R., Skatel, V.J., Lundstedt, G.J., Thomason, J., Brummel-Smith, K. (2000). Assessment of pain in cognitively impaired older adults: a comparison of assessment tools and their use by non professional care givers. J Am Geriatr Soc; 48: S. 1607-1611.

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 7

Zitat (Originalzitat):
“In order to identify the cause(s) of pain, a number of issue s must be considered (Table 5). (…) “

“Table 5
FACTORS RELEVANT TO A PAIN ASSESSMENT

Pain History
- When pain began
- Severity
- Aggravating & relieving factors
- Site
- Qualitiy
- Radiation

General medical history
- Relevant diseases (eg dementia, arthritis, vascular, neurological, gastrointestinal, renal)
- Associates symptoms (eg nausea)
- Allergies

Physical examination
Comprehensive examination covering and including:
- Sites of reported pain an referred pain
- The musculoskeletal and neurological systems
- Signs of arthritis
- Sensory changes (including hypoalgesia or allodynia)

Physical impact of pain
- Impact of pain on activities of daily living
- Spontaneous movement
- Evidence of activity
- Avoidance of activity
- Comfort and movement
- Functional assessment

Psychosocial situation
- Resident´s coping resources
- Resident´s belief about the causes(s) of pain
- Resident´s cognitive state
- Familiy expectations and beliefs about pain and stress
- Presence of anxiety and/or depression
- Effect on sleep
- Suicidal thoughts

Social impacts on pain
- Impact on relationships
- Impact on social activities

Review of medications and other treatments
- Treatments that have been tried
  (list dates and reasons for discontinuation if known)
- Effectiveness of current treatments

Prognosis

Modified from the National Health and Medical Research Council Acute pain guidelines 1999 and the American Geriatrics Society panel guidelines on pain in older persons 2002 (Appendix 2)."

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
The American Geriatrics Society (AGS) (2002). Panel guidelines on persistent pain in older persons, Clinical Practice Guideline.
http://www.americangeriatrics.org/files/documents/2002_persistent_pain_guideline.pdf

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 11

Zitat (Originalzitat):
"Communicative Residents
Whenever verbal communication is feasible and a valid pain report can be obtained, a resident should be assessed with simple questions and screening tools using the resident's preferred language. A discussion indicating interest and raising the issue of pain in varied ways (as described in Section 1) is the best way to introduce the matter of pain intensity. It is important to note that some residents may respond to words such as "soreness" or "discomfort" rather than "pain"."

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 11

Zitat (Originalzitat):
"Multidimensional Pain Assessment
A multidimensional pain assessment instrument is the best choice for the initial assessment of communicative people and subsequent formal reviews at weekly or longer intervals."

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 14
Zitat (Originalzitat): “An Informant Report and Staff Observation of pain-related behaviours (…) are helpful in such cases but more research regarding the assessment of pain in non-communicative people is needed. However, evidence suggests that once pain has been identified as a possible significant issue, the use of a focused observational instrument will help indicate the presence and intensity of pain in these people. (…) observational pain assessment protocols must include both at rest and movement-based (for example, during transfers) periods.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 16
Zitat (Originalzitat): “Residents with borderline communicative capacity There will be many residents who can provide some pain report but whose severity of cognitive impairment reduces the reliability of the report (…) . These residents will be best managed, at least initially, by applying both verbal and observational sets of assessment procedures. (…)”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen .

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 8
Zitat (Originalzitat): “Intensity rating scales. "Some older people may be more willing to score pain on a pain intensity rating scale than say they have pain. Intensity rating scales can enhance the detection of pain in nursing home residents." “
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 7–12

Zitat (Originalzitat):
S. 7:
“i. Screening / Care planning
Evidence based statement:
Self reporting of pain is the gold standard method for identifying pain. (…)
Recommendation: Any health assessment of older people should include asking whether they experience pain (…). The single assessment process should include a question seeking to identify the presence of pain (…)
ii. Finding out about the presence of pain
Evidence based statements
Enquiring about pain when assessing the health of older people is the most effective way of determining the presence of pain. Older people may use a wide range of words to express pain e.g. sore, hurting, aching. In addition to asking a person about pain, the use of an intensity rating scale will enhance the detection of pain. Every effort should be made to facilitate communication particularly with those people with sensory impairments (use of e. g. hearing aids) (…).”
S. 8
“Recommendations
Any health assessment of an older person, including the single assessment process, should include asking whether he/she experiences pain (using terms such as pain, ache, hurt).
The assessment should recognise that older people use a wide range of words to describe pain.
The assessment should recognise that older people may be reluctant to acknowledge and report pain. (…)”
S. 9
“iii. Observation
Evidence based statements
Autonomic signs are often present during severe acute pain, but not in chronic pain, regardless of severity (…) Facial expressions can indicate the presence of pain in older people with and without cognitive impairment. Guarding of body movements can indicate the presence of pain in older people with and without cognitive impairment. Verbalisations or vocalisations including sighing, grunting, groaning, calling out, can indicate pain. Changes in interpersonal interactions e.g. aggression, withdrawal, resisting care can indicate pain. Mental status changes e.g. confusion, crying, distress, irritability can indicate pain (…) Estimation of pain intensity from observation of facial expressions or behaviour is not reliable in older people with and without cognitive impairment (…) Observing patients during physical activity can help identify pain (…)”
S. 11
“Recommendations
In people with difficulty in communicating including cognitive impairment and in situations where procedures might cause pain, an observational assessment is additionally required.
Observations should include facial expressions, body movements, verbalisations, vocalisations, physiology and changes in interpersonal interactions, changes in activity levels and patterns and changes in mental status or affect. Pain behaviours are very individual and clinical judgement and familiarity with the older person is important in interpreting behaviour.
iv Involving families and the interdisciplinary team in the detection and assessment of pain
Evidence based statement
Carers (formal and informal) can augment the detection of the presence of pain. Nursing caregivers tend to underestimate the presence and intensity of pain in nursing home residents. Familiarity with nursing home residents’ usual patterns of behaviour may improve the ability to identify the presence and intensity of pain. (…)”
S. 12:
“Recommendations
Families can be a useful additional source of information with the older person’s consent.”

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 14–15

Zitat (Originalzitat):
“ii. Location of pain
Evidence based statement
The location of pain can be defined by self-pointing in cognitively intact older people.
Pain maps can be used to help locate the site and extent of pain. (…)”
“Recommendations:
An attempt to locate pain should be made by asking the patients to point to the area on themselves. Pain maps should also be used to help locate the site (s) of pain (…)”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 16

Zitat (Originalzitat):
“Functional ability in older people can be measured using activities of daily living (ADL) scales. The Barthel Index[65] is the most commonly used simple ADL scale in use in hospitals and institutional settings. It scores patients in their ability / dependency level for feeding, bathing, personal grooming, dressing, bowel control, bladder control, mobility from bed to chair, ability to get on / off toilet, walking on even surfaces and climbing the stairs. It omits tasks of daily living such as cooking and shopping and therefore needs to be supplemented with an extended ADL measurement scale when assessing patients living in the community.
The Nottingham Extended Activities of Daily Living Scale
assesses activities within four domains: mobility including walking outside and use of public transport; kitchen; domestic including shopping and clothes washing; leisure activities including gardening, driving and going out socially[66]. It was originally developed for use with stroke patients in the community but it has also been validated for use in older people with dyspnoea and chronic airways disease[67, 68].
The multi-dimensional assessment should include details of individual beliefs and strategies used by older people to cope with and relieve pain.
Recommendation
Consider assessment of mood, sleep, mobility, function.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
65. Mahoney, F.I., Barthel, D.W. (1965). Functional evaluation: The Barthel Index. Maryland State Medical Journal; 14: S. 61-65.
66. Nouri, F.M., Lincoln, N.B. (1987). An extended activities of daily living scale for stroke patients. Clinical Rehabilitation; 1: S. 301-305.
67. Yohannes, A.M., Roomi, J., Waters, K., Connolly, M.J. (1997). A comparison of the Barthel index and Nottingham extended activities of daily living scale in the assessment of disability in chronic airflow limitation in old age. Age and Ageing; 27: S. 369-74.
68. Dyer, C.A.E., Singh, S.J., Stockley, R.A., Sinclair, A.J., Hill, S.L. (2002). The incremental shuttle walking test in elderly people with chronic airflow limitation. Thorax; 57: S. 34-38.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 106
Zitat (Originalzitat): “Nonetheless, self-report should be attempted with all patients, as there are individuals with low MMSE scores who can self-report pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: “Hadjistavropoulos, T. (2005). Assessing pain in older persons with severe limitations in ability to communicate. In: Gibson, S.J., Weiner, D. (ed.). Pain in the elderly. Seattle: IASP Press: S. 135-151. doi:10.1097/AJP.0b013e31802be869. Weiner, D.K., Peterson, B.L., Logue, P., Keefe, F.J. (1998). Predictors of pain selfreport in nursing home residents. Aging; 10: S. 411–20.”

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 106
Zitat (Originalzitat): “Central to pain assessment are the self-report of pain and/or the direct observation of pain-related behaviours. Seniors who present with mild to moderate dementia tend to be able to provide valid self-reports of pain. (Hadjistavropoulos et al. 2007) Although nonverbal pain behaviours (e.g., rubbing the affected area, facial reactions, paralinguistic vocalizations) are useful in assessing all pain patients, as cognitive functions deteriorate the assessment emphasis shifts increasingly toward nonverbal responses.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1-S43.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 106
Zitat (Originalzitat): “(…) especially when assessing persons with dementia whose verbal communication abilities are limited, self-report should always be attempted with all patients. When attempting to obtain a self-report of pain from older adults who reside in long-term care facilities, one should take care to use simple and concrete questions. (…)” “An important issue when using self-report scales in this population is the need to be sensitive to the cognitive and sensory changes that often occur with increasing age (e.g., difficulties with vision or hearing).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 108
Zitat (Originalzitat): “Among people with limited ability to communicate, it is especially important to systematize and standardize the observational assessment of pain in a way that maximizes consistency across assessors and circumstances.“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 108
Zitat (Originalzitat): „One important caveat when using observational measures of pain relates to the potential overlap between pain behaviours and symptoms of delirium.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite:110
Zitat (Originalzitat): “Hadjistavropoulos et al. (2007) as well as Herr et al. (2006) highlighted the importance of assessing pain during movement-based tasks and not simply when the older adult is at rest.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1-S43. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs; 7: S. 44-52. doi:10.1016/j.pmn.2006.02.00.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23 (1): S1-S43.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: S3 &1-5, 9-13 (Tabellen)
Zitat (Originalzitat): In der Leitlinie werden detaillierte Empfehlungen ausgesprochen für: “TABLE 1. Recommendations for Physical Evaluation (…)” “TABLE 2. Recommendations for Assessing Pain Using Self-report Procedures (…)” “TABLE 3. Consensus Recommendations for Seniors With Limitations in Ability to Communicate Due to Dementia (…)” “TABLE 4. Recommendations for Functional Assessment (…)” “TABLE 5. Recommendations for the Assessment of Emotional Functioning (…)” “TABLE 9. Essential Clinic History Questions for Older Adults With Persistent Mechanical Low Back ± Leg Pain (…)”

“TABLE 10. Brief Pain Impact Assessment for Patients Who can Communicate Verbally Questions (…)”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Table 2: [107.] Herr, K., Garand, L. (2001). Assessment and measurement of pain in older adults. Clin Geriatr Med.; 17: S. 457–478. [158.] Ferrell, B.A., Ferrell, B.R., Rivera, L. (1995). Pain in cognitively impaired nursing home patients. J Pain Symptom Manage; 10: S. 591–598. [134.] Cleeland, C.S., Ryan, K.M. (1994). Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore; 23: S. 129–138. [167.] Stein, W.M. (2001). Pain in the nursing home. Clin Geriatr Med.; 17: S. 575–594, (viii.) [127.] Melzack, R. (1975). The McGill Pain Questionnaire: major properties and scoring methods. Pain; 1: S. 277–299. Table 3: [148.] Hadjistavropoulos, T. (2005). Assessing pain in older persons with severe limitations in ability to communicate. In: Gibson SJ, Weiner D, ed. Pain in the Elderly. Seattle, WA: IASP Press: S. 135–151. [151.] Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–186. [155.] McGrath, P.A., Seifert, C.E., Speechley, K.N. et al. (1996). A new analogue scale for assessing children’s pain: an initial validation study. Pain; 64: S. 435–443. [156.] Scherder, E.J.A., Bouma, A. (2000). Visual Analogue Scales for pain assessment in Alzheimer’s disease. Gerontology; 46: S. 47–53. [165.] Fuchs-Lacelle, S., Hadjistavropoulos, T. (2004). Development and preliminary validation of the pain assessment checklist for seniors with limited ability to communicate (PACSLAC). Pain Manage Nurs; 5: S. 37–49. [178.] Snow, A.L., Weber, J.B., O’Malley, K.J. et al. (2004). NOPPAIN: a nursing assistant-administered pain assessment instrument for use in dementia. Dement Geriatr Cogn Disord; 17: S. 240–246. [179.] Wary, B., Doloplus, C. (1999). Doloplus-2, a scale for pain measurement. Soins Gerontol; 19: S. 25–27. [183.] Villanueva, M.R., Smith, T.L., Erickson, J.S. et al. (2003).Pain Assessment for the Dementing Elderly (PADE): reliability and validity of a new measure. J Am Med Dir Assoc; 4: S. 1–8. Table 4: 44/45/198/216/222/ [44.] Guralnik, J.M., Simonsick, E.M., Ferrucci, L. et al. (1994). A short physical performance battery assessing lower extremity function: association with self-reported disability and prediction of mortality and nursing home admission. J Gerontol; 49: S. M85–M94. [45.] Podsiadlo, D., Richardson, S. (1991). The timed ‘‘Up & Go’’: a test of basic functional mobility for frail elderly persons. J Am Geriatr Soc; 39: S. 142–148. [198.] Farrell, M.J., Gibson, S.J., Helme, R.D. (1996). Measuring the activity of older people with chronic pain. Clin J Pain.; 12: S. 6–12. [216.] Daltroy, L.H., Phillips, C.B., Eaton, H.M. et al. (1995). Objectively measuring physical ability in elderly persons: the physical capacity evaluation. Am J Public Health; 85: S. 558–560. [222.] Jette, A.M. (1987). The Functional Status Index: reliability and validity of a self-report functional disability measure. J Rheumatol Suppl.; 14 (suppl 15): S. 15–21. Table 5: 273/274/275/287/292/299 [273.] Yesavage, J.A., Brink, T.L., Rose, T.L. et al. (1982). Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res;17: S. 37–49. [274.] Koenig, H.G., Meador, K.G., Cohen, H.J. et al. (1988). Self-rated depression scales and screening for major depression in the older hospitalized patient with medical illness. J Am Geriatr Soc; 36: S. 699–706. [275.] Parmelee, P.A., Lawton, M.P., Katz, I.R. (1989). Psychometric properties of the geriatric depression scale among the institutionalized aged. J Consult Clin Psychol; 1: S. 331–338. [287.] Beck, A.T., Epstein, N., Brown, G. et al. (1988). An inventory for measuring clinical

anxiety: psychometric properties. J Consult Clin Psychol; 56: S. 893–897.
[292.] McCracken, L.M., Zayfert, C., Gross, R.T. (1992). The Pain Anxiety Symptoms Scale: development and validation of a scale to measure fear of pain. Pain; 50: S. 67–73.
[299.] Owens, K.M.B., Hadjistavropoulos, T., Asmundson, G.J.G. (2000). Addressing the need for appropriate norms when measuring anxiety in seniors. Aging Ment Health; 4: S. 309–314.
Table 10: Copyrighted by the Springer Publishing Company, LLC, New York, New York 10036. Used with permission from ‘‘Comprehensive interdisciplinary assessment and treatment planning: An integrative overview’’ by D. K. Weiner and K. Herr, in D. Weiner, K. Herr, K. & T. Rudy (ed.) (2002). Persistent Pain in Older Adults: An Interdisciplinary Guide for Treatment. New York, NY: Springer Publishing Company; 21

HCANJ _2006
Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 5

Zitat (Originalzitat):
“If the resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal resident. Additionally, the facility shall seek information from the resident’s family, caregiver or other representative, if available and known to the facility.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 12

Zitat (Originalzitat):
“Obtain a self-report of pain from the older individual if at all possible. The single most reliable indicator of the existence and intensity of pain is the patient’s self report (AGS, 2002; APS, 2003; VHA/DoD, 2002). D”

Evidence-Grad: siehe Referenzen: IV-a – V-b
Empfehlungsstärke: D

Referenzen:
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society, 50 (Suppl. 6), S205-S224. (IV-a).
APS. American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (Fifth ed.). Glenview, Illinois: American Pain Society (APS). (V-b).
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 12-13

Zitat (Originalzitat):
“Ask the patient to mark on a diagram or to point to the site of the pain. Pain maps or drawings can be used with cognitively intact and impaired older adults to identify the location of pain. (See Appendix A for an example of a pain assessment tool.) (Weiner et al. 1998a; Wynne et al. 2000).—C“

Evidence-Grad: siehe Referenzen: III-a
Empfehlungsstärke: C

Referenzen:
Weiner, D., Peterson, B., Keefe, F. (1998a). Evaluating persistent pain in long term care residents: What role for pain maps? Pain; 76 (1-2): S. 249-257. (III-a).
Wynne, C.F., Ling, S.M., Remsburg, R. (2000). Comparison of pain assessment instruments in cognitively intact and cognitively impaired nursing home residents. Geriatric Nursing; 21 (1): S. 20-23. (III-a).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 13

Zitat (Originalzitat):
“Investigate pain terminology typically used by the patient and use this term throughout assessment and management of pain. While “pain” is the standard term used in this practice guideline, it is commonly recognized that many older individuals use other terms (e.g., “sore”, “ache”, “discomfort”). Ask about pain with a simple question to start, such as “Are you feeling pain?” If the individual denies pain when first asked, ask again in a different manner, such as “Are you uncomfortable right now?” or “Do you hurt anywhere?” “

Evidence-Grad: siehe Referenzen: III-a, V-a, Vb
Empfehlungsstärke: B

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Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 13

Zitat (Originalzitat):
"Assess pain intensity by selecting a tool based on the patient's preferences and cognitive/functional abilities, and then use the same tool consistently. Most older adults can use pain scales, depending on individual cognitive, education, psychomotor and sensory factors. -B"

Evidence-Grad: siehe Referenzen: II-a -V-a
Empfehlungsstärke: B

Referenzen:
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Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 14:

Zitat (Originalzitat):
"Adapt tools to compensate for sensory impairments. Consider auditory impairment (e.g., position your face in view of the patient, speak in a slow, normal tone of voice, reduce extraneous noises, provide written instructions) and visual impairment (use simple lettering, at least 14 point font size, adequate line spacing, and nonglare paper such as buff-colored). Assure that the patient has eyeglasses, functioning hearing aids, and adequate time to respond to questions (AGS 2002; Manz et al. 2000; VHA/DoD 2002. -**C"**

Evidence-Grad: siehe Referenzen III-a – IV-b
Empfehlungsstärke: C

Referenzen:
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Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 18-21

Zitat (Originalzitat): **"Pain Assessment of Cognitively Impaired Older Adults**
This section regarding the special pain assessment needs of cognitively impaired older adults should be used to supplement the previous section on pain assessment. In principle, the following hierarchy of importance of basic measures of pain presence and intensity should be considered when assessing pain:
1. Patient's self-report using a pain rating scale (e.g., VDS, Faces, NRS 0-10)
2. Pathological conditions or procedures that usually cause pain
3. Behaviors (e.g., facial expressions, crying)
4. Report of pain from a family member or others close to the patient
5. Physiological measures such as blood pressure or heart rate are the least sensitive indicators of pain
(McCaffery & Pasero, 1999).—**E "**
"1. **Assess cognitive status of older adult patients. Screen for cognitive impairment using reliable tools. Differentiate between delirium and dementia as managing pain and other aspects of care may vary depending on condition.** (…)"
"3. **Ask about pain in the present.** Older adults with memory impairment may often be able to report reliably in the here and now, but have difficulty remembering past pain experiences, including their earlier ratings of pain (AGS, 2002; Bergh et al., 2000; Feldt et al., 1998a; Miller et al., 1996).**—B"**

"4. **Elicit pain statements from cognitively impaired patients, and attempt to use a selected assessment tool.** Older adults with mild to moderate cognitive impairment are often able to rate pain using self-report instruments and individual patient ability to do so should be assessed. It may be necessary to try several tools to evaluate which one is most easily used by the cognitively impaired individual. Also many severely impaired persons can respond to simple questioning about presence of pain and may be able to use a simple rating scale. Scales that are the simplest and most usable for cognitively impaired older adults include verbal descriptor scales, pain thermometers, and faces pain scales (Briggs & Closs, 1999; Buffum et al., 2001; Chibnall & Tait, 2001; Closs et al., 2004; Feldt et al., 1998a; Ferrell, 1995; Herr & Mobily, 1993; Herr et al., 2004b; Kaasalainen & Crook, 2003; Krulewitch et al., 2000; Manz et al., 2000; McCaffery & Pasero, 1999; Porter et al., 1996; Scherder et al., 2003a; Taylor et al., 2005; Taylor & Herr, 2003; Weiner et al., 1998b; Wynne et al., 2000).**—C"**

"5. **For older adults with cognitive impairment unable to report pain, assess for the presence of factors that cause pain.** Whenever an older adult with cognitive impairment shows a change in mental status, pain should be considered a potential etiology. Potential sources of pain include distended bladder, incision, infection, inflammation, fracture, positioning, UTI, and constipation. Treat the underlying cause of pain using etiology specific interventions (Closs & Briggs, 2002; Kovach et al., 1999; Miller et al., 1996; Pasero et al., 1999c; VHA/DoD, 2002).**—B** (…)"

"8. **Observe for the following behavioral indicators of pain in patients who are unable to provide self-report.** The most common indicators are underlined. Behavioral indicators can be used to help assess pain in all patients, but they do not take precedence over self-report. **Nonverbal cues/behaviors**: restlessness, agitation, withdrawing, rapid blinking, rocking, rubbing, fidgeting, guarding or splinting operative or injured site, bracing, repositioning, tense body language, distorted posture, noisy breathing (Baker et al., 1996; Bell, 1997; Closs et al., 2005; Feldt, 2000; Feldt et al., 1998a; Fuchs-Lacelle & Hadjistavropoulos, 2004; Hurley et al., 1992; Kovach et al., 2002; Kovach et al., 1999; Manfredi et al., 2003a; Manfredi et al., 2003b; Marzinski, 1991; Mateo & Krenzischek, 1992; Miller et al., 1996; Raway, 1993; Simons & Malabar, 1995; Weiner et al., 1999).**—C**

 Facial expressions of pain: brow lowering with jawdrop or mouth open; brow lowering with narrowing or closing eyes, clenched teeth, sad or distorted expression, frowning, grimacing, wincing, wrinkling of the forehead (Baker et al., 1996; Feldt, 2000; Hadjistavropoulos et al., 2000; Hurley et al., 1992; Kovach et al., 1999; Manfredi et al., 2003a; Mateo & Krenzischek, 1992; Prkachin, 1993; Raway, 1993; Scherder et al., 2003b).**—C**

 Vocalizations: groaning, moaning, crying, yelling, sighing, grunting, perseverant vocalizations, verbal outbursts such as use of profanity or words of protest (Closs et al., 2005; Feldt, 2000; Feldt et al., 1998a; Hurley et al., 1992; Kovach et al., 1999; Mateo & Krenzischek, 1992; Raway, 1993).**—C**

 Mental status changes: new onset or increased severity of delirium, agitation/irritability, anxiety, depression (AGS, 2002; Kovach et al., 1999; Manfredi et al., 2003a; Manfredi et al., 2003b).**—C**

 A change in usual behavior: aggression, withdrawal, impaired mobility or change in activity, altered sleep, fatigue, attention seeking, change in appetite or refusal to eat, withdrawal, resistance to care (Baker et al., 1996; Feldt, 2000; Feldt et al., 1998b; Fuchs-Lacelle & Hadjistavropoulos, 2004; Kovach et al., 1999; Marzinski, 1991).**—C"**

Evidence-Grad: siehe Referenzen II-a - IVb
Empfehlungsstärke: B, C und E

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Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 19

Zitat (Originalzitat):
“Observe behavior when the patient is engaged in activity (e.g., transfers, ambulation, repositioning) as observation at rest can be misleading (Bell 1997; Feldt 2000; Feldt et al. 1998a; Hadjistavropoulos et al. 2000; Raway 1993).—C”

Evidence-Grad: siehe Referenzen: III-a
Empfehlungsstärke: C

Referenzen:
Bell, M.L. (1997). Postoperative pain management for the cognitively impaired older adult. Seminars in Perioperative Nursing; 6 (1): S. 37-41. (III-a).
Feldt, K. (2000). The checklist of nonverbal pain indicators (CNPI). Pain Management Nursing; 1 (1). S: 13-21. (III-a).
Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a).
Hadjistavropoulos, T., LaChapelle, D.L., MacLeod, F.K., Snider, B., Craig, K.D. (2000). Measuring movement-exacerbated pain in cognitively impaired frail elders. Clinical Journal of Pain; 16 (1): S. 54-63. (III-a).
Raway, B. (1993). Pain behaviors and confusion in elderly patients with hip fracture (DISS). Washington, D.C.: The Catholic University of America. (III-a).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 21

Zitat (Originalzitat):
“If the patient is verbally unresponsive or noncommunicative, try to elicit from the family or caregiver the patient's usual pain behaviors such as withdrawal, agitation, facial grimacing, guarding, moaning (AGS 2002; Herr & Garand 2001; Hurley et al. 1992; Manfredi et al. 2003a; Manfredi et al. 2003b; Prkachin 1993; Shega et al. 2004; Zalon 1999).—C”

Evidence-Grad: siehe Referenzen II-a – IV-a
Empfehlungsstärke: C

Referenzen:
AGS (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a).
Herr, K., Garand, L. (2001). Assessment and Measurement of Pain in Older Adults. Clinics in Geriatric Medicine; 17 (3): S. 457-478. (IV-a).
Hurley, A.C., Volicer, B.J., Hanrahan, P.A., Houde, S., Volicer, L. (1992). Assessment of discomfort in advanced Alzheimer patients. Research in Nursing & Health, 15, 369-377. (IIIa).
Manfredi, P.L., Breuer, B., Meier, D.E., Libow, L. (2003a). Pain assessment in elderly patient with severe dementia. Journal of Pain & Symptom Management, 25 (1): S. 48-52. (III-a).
Manfredi, P.L., Breuer, B., Wallenstein, S., Stegmann, M., Bottomley, G., Libow, L. (2003b). Opioid treatment for agitation in patients with advanced dementia. International Journal of Geriatric Psychiatry; 18 (8): S. 700-705. (II-a).
Prkachin, K.M. (1993). The consistency of facial expressions of pain: A comparison across modalities. Pain, 51, 297-306. (II-b).
Shega, J.W., Hougham, G.W., Stocking, C.B., Cox-Hayley, D., Sachs, G.A. (2004). Pain in community-dwelling persons with dementia: frequency, intensity, and congruence between patient and caregiver report. Journal of Pain & Symptom Management; 28 (6): S. 585-592. (IIIa).
Zalon, M.L. (1999). Comparison of pain measures in surgical patients. Journal of Nursing Measurement; 7 (2): S. 135-152. (III-a).

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Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 4

Zitat (Originalzitat):

- „Strategies of pain assessment
- Review medical history, physical examinations, and laboratory and diagnostic tests to understand the sequence of events contributing to pain (AGS, 2002 **[Level VI]**).
- Asses present pain, including intensity, character, frequency, patterm, location, duration, and precipitating and relieving factors (AGS, 2002 **[Level VI]**).
- Review medications, including current and previously used prescription drugs. Over-the-counter drugs, and home remedies. Determine which pain control methods have previously been effective for the patient. Asses patient´s attitudes and beliefs about use of analgesics, adjuvant drugs, and nonpharmacological treatments (AGS, 2002 **[Level VI]**).
- Use a standardized tool to assess self-reported pain. Choose from published measurement tools, and recall that older adults may have difficulty using 10-point visual analog scales. Vertical verbal descriptor scales or faces scaöes may be more useful with older adults (Taylor et al., 2005) **[Level V]**).
- Asses pain regulary and frequently, but at least every 4 hours. Monitor pain intensity after giving medications to evaluate effectiveness.
- Observe of nonverbal and behavioral signs of pain, such as facial grimacing, withdrawing, guarding, rubbing, limping, shifting of position, aggression, agitation, depression, vocalization, and cryin. Also watch for changes in behavior from patient´s usual patterns (Taylor et al., 2005) **[Level V]**).
- Gateher information from family members about the patient´s pain experiences. Ask about patients verbal and nonverbal/behavioral expression of pain, particulary in older adults with dementia.
- When pain is suspected but assessment instruments or observation is ambiguous, institute a clinical trial of pain treatment (i.e., in persons with dementia). If symptoms persist, assume pain is unrelieved and treat accordingly (Herr, et al, 2006 **[Level V]**)."

Evidence-Grad: **Level V - VI**
Empfehlungsstärke: nicht ausgewiesen

Referenzen:
AGS Panel on Persistant Pain in Older Persons (2002). The management of persistant pain in older persons. J Am Geriatr Soc; 50 (6 Suppl): S. 205-224.
Herr, K., Coyne P.J., Key, T., Manworren, R., McCaffrey, M., Merkel, S., Pelosi-Kelly, J., Wild, L. (2006). American Society for Pain Management Nursing. Pain assessment in the nonverbal patient: position statement with practice Recommendations.
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Mc Lennon_2005
Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 6

Zitat (Originalzitat):
“The proposed intervention for management of persistent pain in older adults is comprised of:
1. Assessment: Pain and Functioning
2. Assessment in Cognitively Impaired Older Adults
• Self-reports
• Proxy Reports
• Observational Methods
• Algorithm
3.Pain Intensity Scales”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Mc Lennon_2005
Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 10

Zitat (Originalzitat):
“cognitive, sensory, perceptual, and motor functions are present that may hamper the older persons’ ability to effectively and accurately complete the pain tool assessment. Strategies such as improved lighting, simple language, enlarged and bold print, avoiding glare and background noise may be helpful (Burris 2004; Hanks-Bell et al. 2004).”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. 1-20. (N)
Burris, J.E. (2004). Pharmacologic approaches to geriatric pain management. Archives of Physical Medicine and Rehabilitation; 85: S. S45-S49. (L)
Hanks-Bell, M., Halvey, K., Paice, J.A. (2004). Pain assessment and management in aging. Online Journal of Issues in Nursing, 9. Retrieved from the world wide web on July 18, 2004. www.nursingworld.org/ojin/topic21/tpc21_6.htm (L)
Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults: Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20: S. 207-218. (R)
Joint Commission on Accreditation of Healthcare Organizations. (2001). Accreditation manual for hospitals. Oakbrook Terrace, IL: Author. (N)
McCaffery, M., Pasero, C. (1999a). Assessment: underlying complexities, misconceptions, and practice tools. In M. McCaffery & C. Pasero (ed.), Pain: clinical manual; 2nded: S. 35-102. Philadelphia: Mosby. (L)
Weiner, D.K., Herr, K., Rudy, T.E. (ed.) (2002). Persistent pain in older adults. New York: Springer. (L)

Mc Lennon_2005
Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 7-9

Zitat (Originalzitat):
Assessment in Cognitively Impaired Older Adults
“Self-reports: (…)
However, there is no evidence that cognitive impairment reduces the ability to feel painful stimuli, instead it may reduce the ability to interpret and report pain depending upon the extent and location of neuron loss (Bachino, Snow, Kunik, Cody, & Wristers 2001; Huffman &

Kunik, 2000; Young & Young 1997. Evidence Grade = C).
Therefore, assessing pain via self-report in this group is challenging. Mild to moderately impaired older adults can self-report their pain intensity (Chibnall & Tait 2001; Taylor, Harris, Epps, & Herr 2005) (…)"
"Proxy-reports:
Caregivers, nurses, and other health care providers commonly estimate pain ratings for those who are unable to communicate pain for themselves. However, this method can be problematic for the following reasons. Nursing staff and others may underestimate pain in cognitively impaired nursing home residents due to lack of recognition (Cohen-Mansfield 2005; Cohen-Mansfield & Lipson 2002. Evidence Grade = C). Also, there may be incongruence between staff and patient, and caregiver and patient ratings of pain due to family caregiver overestimation or staff underestimation of pain (Horgas & Dunn 2001; Shega, Hougham, Stocking, Cox-Hayley, & Sach 2004. Evidence Grade = C). In spite of these difficulties, caregivers and health care providers can be instrumental in assessing and managing persistent pain in this group. (…) "
"Observational Methods:
Several observational methods have been developed and tested to assess pain in noncommunicative older adults with severe dementia but have not been adequately tested for practical, clinical use. Two particularly promising measures are The Checklist for Nonverbal Pain Behaviors (CNBP) … and the NOPPAIN
Although a specific tool is not recommended in this guideline, the literature supports the following as indicators of inadequately treated pain. These clues may also indicate that other processes may be occurring such as constipation, hunger, thirst, depression, and infection. Therefore, a thorough assessment for all potential causes should be undertaken and assistance sought when needed.
• Changes in typical behavior (Davis & Srivastava 2003; Kovach et al. 2000; Mentes, Teer, & Cadogan 2004; Soscia 2003. Evidence Grade = C).
• Inactivity or lying down (Weiner et al. 1999. Evidence Grade = C).
• Facial grimacing or wincing (Kovach et al. 2000; Mentes et al. 2004; Manfredi, Breuer, Meier, & Libow 2003; Evidence Grade = C).
• Limping, gait changes, shifting in body weight, holding on to supports (Birrell et al. 2000; Kovach et al. 2000; Walker et al. 2001. Evidence Grade = C).
• Bracing, rubbing, rocking (Feldt 2000b; Hanks-Bell, Halvey, & Paice 2004; Kovach et al. 2000. Evidence Grade = C).
• Disruptive behaviors, e.g., agitation, restlessness, verbalizations, aggression, wandering (Buffum et al. 2001; Kiely, Morris, & Algase 2000; Manfredi et al. 2003; Opie et al. 2002. Evidence Grade = C).
• Resistance to care (Zieber et al. 2005. Evidence Grade = C).
• Decreased appetite, insomnia, apathy (Herr & Garand 2001; Kovach et al. 2000. Evidence Grade = C)."
Algorithm for Assessing Pain in Severe Dementia:
"In addition, to self-reports, proxy reports, and observational methods, the algorithm in Appendix B (Weiner, Herr, & Rudy 2003) may be used as a guide to pain assessment in this group. The algorithm begins with assessing for pain behaviors during movement. If noted, consider premedicating the patient prior to movement, strategies to reduce pain, and reassurance while continuing to watch for pain-indicating behaviors. If no pain behaviors are noted during movement, but the patient exhibits other behaviors that suggest pain, then assess for basic comfort measures such as toileting, thirst, and hunger or underlying pathologies such as infection or constipation. The final step is to treat the identified cause or consider an empiric analgesic trial. [Anm. Vgl Algorithmus in der LL Appendix B)"

Evidence-Grad und/oder Empfehlungsstärke: Evidence Grade = C

Referenzen:

Bachino, C., Snow, A.L., Kunik, M.E., Cody, M., Wristers, K. (2001) Principles of pain assessment and treatment in non-communicative demented patients. Clinical Gerontology; 23: S. 97- 115. (L)

Baker, A., Bowring, L., Brignell, A., Kafford, D. (1996). Chronic pain management in cognitively impaired patients: a preliminary research report. Perspectives; 20: S. 4-8. (R).

Birrell, F., Croft, P., Cooper, C., Hosie, G., MacFarlane, G., Silman, A. (2000). Health impact of pain in the hip region with and without radiographic evidence of osteoarthritis: a study of new attenders to primary care. The PCR Hip Study Group. Annals of Rheumatic Diseases; 59: S. 857-863. (R)

Buffum, M.D., Sands, L., Miaskowski, C., Brod, M., Washburn, A. (2004). A clinical trial of the effectiveness of regularly scheduled acetaminophen versus as-needed administration of acetaminophen in the management of discomfort in older adults with dementia. Journal of the American Geriatrics Society; 52: S. 1093-1097. (R)

Buffum, M.D., Miaskowski, C., Sands, L., Brod, M. (2001). A pilot study of the relationship between discomfort and agitation in patients with dementia. Geriatric Nursing; 22: S. 80-85. (R)

Chibnall, J., Tait, R. (2001). Pain assessment in cognitively-impaired and unimpaired older adults: A comparison of four scales. Pain; 92: S. 173-186. (R)

Cohen-Mansfield, J. (2005). Nursing staff members' assessments of pain in cognitively impaired nursing home residents. Pain management nursing; 6: S. 68-75. (R)

Cohen-Mansfield, J., Lipson, S. (2002). The underdetection of pain of dental etiology in persons with dementia. American Journal of Alzheimer's Disease and Other Dementias; 17: S. 249-253. (R)

Davis, M.P., Srivastava, M. (2003). Demographics, assessment and management of pain in the elderly. Drugs & Aging; 20: S. 23-57. (L)

Feldt, K. (2000b). The checklist of nonverbal pain indicators (CNPI). Pain Management Nursing; 1: S. 13-21. (R)

Hanks-Bell, M., Halvey, K., Paice, J.A. (2004). Pain assessment and management in aging. Online Journal of Issues in Nursing; 9. Retrieved from the world wide web on July 18, 2004. www.nursingworld.org/ojin/topic21/tpc21_6.htm (L)

Herr, K., Garand, L. (2001). Assessment and measurement of pain in older adults. Clinics in Geriatric Medicine; 17: S. 457-478. (L)

Horgas, A. L., Dunn, K. (2001). Pain in nursing home residents. Journal of Gerontological Nursing; 27: S. 44-53. (R)

Huffman, J.C, Kunik, M.E. (2000). Assessment and understanding of pain in patients with dementia. Gerontologist; 40: S. 574-581. (L)

Kiely, D.K., Morris, J.N., Algase, D.L. (2000). Resident characteristics associated with wandering in nursing homes. International Journal of Geriatric Psychiatry; 15: S. 1013-1020. (R)

Kovach, C.R., Griffie, J., Muchka, S., Noonan, P.E., Weissman, D.E. (2002). The assessment of discomfort in dementia protocol. Pain Management Nursing; 3: S. 16-27. (R)

Kovach, C.R., Griffie, J., Muchka, S., Noonan, P.E., Weissman, D.E. (2000). Nurses' perceptions of pain assessment and treatment in the cognitively impaired elderly. Clinical Nurse Specialist; 14: S. 215-220. (R)

Manfredi, P.L., Breuer, B., Meier, D.E., Libow, L. (2003). Pain assessment in elderly patients with severe dementia. Journal of Pain and Symptom Management; 25: S. 48-52. (R)

Mentes, J.C., Teer, J., Cadogan, M.P. (2004). The pain experience of cognitively impaired nursing home residents: perceptions of family members and certified nursing assistants. Pain Management Nursing; 5: S. 118-125. (R)

Opie, J., Doyle, C., O'Connor, D.W. (2002). Challenging behaviors in nursing home residents with dementia: a randomized controlled trial of multidisciplinary interventions. International Journal of Geriatric Psychiatry; 17: S. 6-13. (R).

Shega, J.W., Hougham, G.W., Stocking, C.B., Cox-Hayley, D., Sach, G.A. (2004). Pain in community dwelling persons with dementia: frequency, intensity, and congruence between patient and caregiver report. Journal of Pain and Symptom Management; 28: S. 585-592. (R)

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Taylor, L.J., Harris, J., Epps, C.D., & Herr, K. (2005). Psychometric evaluation of selected pain intensity scales for use with cognitively impaired and cognitively intact older adults. Rehabilitation Nursing; 30: S. 55-61. (R)
Young, P.A., Young, P.H. (1997). The somatosensory system. In J. Velker, (ed.)., Basic clinical neuroanatomy: S. 127-151. Baltimore: Williams & Wilkins. (L)
Walker, C.R., Myles, C., Nutton, R., Rowe, P. (2001). Movement of the knee in osteoarthritis. The use of electrogoniometry to assess function. Journal of Bone & Joint Surgery British Volume; 83: S. 195-198. (R)
Weiner, D.K., Peterson, B., Keefe, F. (1999). Chronic pain-associated behaviors in the nursing home: resident versus caregiver perceptions. Pain; 80: S. 577-588. (R).
Weiner, D.K., Peterson, B., Ladd, K., McConnell, E., Keefe, F. (1999). Pain in nursing home residents: An exploration of prevalence, staff perspectives, and practical aspects of measurement. Clinical Journal of Pain; 15: S. 92-101. (R)
Werner, P., Cohen-Mansfield, J., Watson, V., Pasis, S. (1998). Pain in participants of adult day care centers: Assessment by different raters. Journal of Pain and Symptom Management; 15: S. 8-17. (R)
Weiner, D.K., Herr, K., Rudy, T.E. (ed.) (2002). Persistent pain in older adults. New York: Springer. (L)
Zieber, C.G., Hagen, B., Armstrong-Esther, C., Aho, M. (2005). Pain and agitation in longterm care residents with dementia: use of the Pittsburgh Agitation Scale. International Journal of Palliative Nursing; 11: S. 71-78. (R)

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 10, 39 (2002) & 130 (2007)

Zitat (Originalzitat):
“Self-report is the primary source of assessment for verbal, cognitively intact persons. Family/care provider reports of pain are included for children and adults unable to give self-report. Grade of Recommendation =C”

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation =C

Referenzen: aus Version 2007

Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
Cavender, K., Goff, M.D., Hollon, E.C., Guzzetta, C.E. (2004). Parents’ positioning and distracting children during venipuncture: Effects on children’s pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56.
Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research; 35 (4): S. 58-71.
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
Malviya, S., Voepel-Lewis, T., Burke, C., Merkel, S., Tait, A.R. (2006). The revised FLACC observational pain tool: Improved reliability and validity for pain assessment in children with cognitive impairment. Paediatric Anaesthesia; 16 (3): S. 258-265.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.

van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 42 (2002)

Zitat (Originalzitat):
“Older people may present substantial barriers to accurate pain assessment. They may be reluctant to report pain despite substantial physical or psychological impairment. Sensory and cognitive impairment, common among frail older people, make communication more difficult. The American Geriatric Society Panel on Chronic Pain in Older Persons states that even people with mild to moderate cognitive impairment can be assessed with simple questions and screening tools. Reports from caregivers should be also be sought out. (AGS, 1998)”

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation =C

Referenzen:
American Geriatrics Society (1998). Panel on Chronic Pain in Older Persons. The management of chronic pain in older persons. Journal of American Geriatrics Society; 46 (5): S. 635-651.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 28 (Teil II)

Zitat (Originalzitat):
“Gebaseerd op de literatuur kan worden vastgesteld dat patiënten met een Mini Mental Status Examination (MMSE) van 18 en hoger op een valide en reliabele manier pijn kunnen aangeven met behulp van een zelfrapportage instrument” (Jensen et al, 1998; Weiner et al, 1999a; Scherder & Bouma, 2000; Chibnall & Tait, 2001).

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173-86.
Jensen, M.P., Miller, L., Fisher, L.D. (1998). Assessment of pain during medical procedures: a comparison of three scales. Clin J Pain.; 14 (4): S. 343-349.
Scherder, E.J.A., Bouma, A. (2000). Visual Analogue scales for pain assessment in Alzheimer’s Disease. Gerontology; 46: S. 47-53.
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Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 28 (Teil II)

Zitat (Originalzitat):

“Zelfrapportage van pijn is voor kwetsbare ouderen zonder of met milde tot matige cognitieve/communicatieve beperkingen de gouden standaard om pijn te identificeren.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173-86. Jensen, M.P., Miller, L., Fisher, L.D. (1998). Assessment of pain during medical procedures: a comparison of three scales. Clin J Pain; 14 (4): S.343-9. Scherder, E.J.A., Bouma, A. (2000). Visual Analogue scales for pain assessment in Alzheimer’s Disease. Gerontology; 46: S. 47-53. Weiner, D.K., Peterson, B., Ladd, K., McConnell, E.R.N., Keefe, F. (1999a). Pain in nursing home residents: An exploration of prevalence, staff perspectives and practical aspects of measurement. Clinical Journal of Pain; 15 (2): S. 92-101.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 9 (Teil I)
Zitat (Originalzitat): **“Zelfrapportage van kwetsbare ouderen over pijn** (zie deel 2, paragraaf 3.2.1) (...) 3a) Omdat kwetsbare ouderen niet snel hun pijn uiten is het zinvol dat in de contacten met kwetsbare ouderen naar pijn wordt gevraagd. 3b) Bij de dagelijkse zorg dient aan kwetsbare ouderen zonder of met milde tot matige cognitieve/communicatieve beperkingen gevraagd te worden of zij pijn hebben. 3 c) Bij de dagelijkse zorg dient bij kwetsbare ouderen met ernstige cognitieve/communicatieve beperkingen daarnaast ook pijn te worden geobserveerd, liefst met hulp van verzorgenden en mantelzorgers.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zi Hadjistavropoulos et al. 2007

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 9 (Teil I)
Zitat (Originalzitat): “vgl. Aanbevelingen over pijnbeleving en -gedrag bij kwetsbare ouderen 2a) Stimuleer kwetsbare ouderen hun pijnervaring, eventuele vragen of twijfels over pijnbestrijding te uiten. 2b) Houd bij de interpretatie van uitingen over pijn en bij geobserveerd pijngedrag rekening met een mogelijk andere pijnbeleving en pijngedrag van kwetsbare ouderen. 2c) Houd rekening met de mogelijkheid van afwijkend(e) pijnbeleving en -gedrag van kwetsbare ouderen, zeker bij cognitieve stoornissen en specifieke aandoeningen zoals de ziekte van Parkinson, MS, CVA, dementiesyndromen en de ziekte van Huntington. 2d) Wees alert op de mogelijkheid van centrale pijn, zeker bij kwetsbare ouderen, al of niet met cognitieve en/of communicatieve beperkingen, die hevig reageren op lichte aanrakingen 2e) Hanteer een stapsgewijze methode voor het bepalen van de intensiteit, locatie en oorzaken van de pijn om een passende behandeling in te stellen. Deze methode is: 1 zelfrapportage 2 anamnese 3 heteroanamnese: bevragen van mantelzorgers en of verzorgenden/verpleging over pijn en

gedragsverandering van de patiënt (zeker bij kwetsbare ouderen met communicatieve beperkingen) 4 observatie 5 bepalen gevolgen van pijn 6 lichamelijk onderzoek en vaststellen oorzaken pijn. Daarna kan een adequate pijnbehandeling worden gestart.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 21: Wie können diese Informationen gewonnen werden?
Seite: 9 (Teil I) & 29- 30 (Teil II)
Zitat (Originalzitat): **“Het afnemen van een (pijn)anamnese bij kwetsbare ouderen** (zie deel 2, paragraaf 3.2.2) 3d) Als onderdeel van de dagelijkse zorg en in het contact met een kwetsbare oudere zonder of met milde tot matige cognitieve/ communicatieve beperkingen dient gevraagd te worden of men pijn ervaart (met behulp van termen zoals ‘pijn’, ‘zeer’,gevoelig’). 3e) Bij de beoordeling dient men te beseffen, dat kwetsbare ouderen: – een breed scala van woorden gebruiken om de pijn te beschrijven, en – minder geneigd zijn om pijn te erkennen en pijn te melden. 3 f) Om de communicatie over pijn te ondersteunen kan bij kwetsbare ouderen met zintuiglijke beperkingen gebruik worden gemaakt van hulpmiddelen. Bijvoorbeeld een gehoorapparaat bij gehoorproblemen, of pijnmeetinstrumenten met sterk uitvergrote letter bij visusproblemen. Als onderdeel van de dagelijkse zorg en in het contact met een kwetsbare oudere met ernstige cognitieve/communicatieve beperkingen dient daarnaast extra aandacht te worden geschonken aan het observeren van potentiële (gedrags-) indicatoren van pijn, zie paragraaf 3.2.4. Naast het vragen naar de aanwezigheid van pijn kan het gebruik van een pijnmeetinstrument helpen om (de mate van) pijn vast te stellen en het effect van de pijnbehandeling te volgen.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 2007, zie Hadjistavropoulos et al 2007
Baier, R.R., Gifford, D.R., Patry, G., Banks, S.M., Rochon, T., De Silva, D., Teno, J.M. (2004). Ameliorating pain in nursing homes: a collaborative quality improvement project. JAGS; 52: S. 1988-95.
Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2001). Assessing pain and pain relief in geriatric patiënts with non-Pathological fractures with different rating scales. Aging Clinical Experimental Research;13: S. 355-61.
Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patiënts. Aging Clin Exp Res; 12: S. 380-387.
Closs, S.J., Briggs, M. (2002). Patiënts' verbal descriptions of pain and discomfort following orthopaedic surgery. International Journal of Nursing Studies; 39: S. 563-72.
Duggleby, W. (2002). The language of pain at the end of life. Pain Management Nursing; 3 (4): S. 154-160.
Gagliese, L., Melzack, R. (2003a). Agerelated differences in the qualities but not the intensity of persistent pain. Pain; 104: S. 597-608.
Gagliese, L., Katz, J. (2003b). Age differences in postoperative pain are scale dependent: a comparison of measures of pain intensity and quality in younger and older surgical patiënts. Pain; 103: S. 11-20.
Kamel, H.K., Phlavan, M., Malekgoudarzi, B., Gogal, P., Morley, J.E. (2001). Utilizing pain assessment scales increases the frequency of diagnosing pain among elderly nursing home residents. J Pain Symptom Management; 21: S. 450-55.
Schofield, P.A. (2006). Talking to older people in care homes: Perceptions of their pain and their preferred management strategies. Results of a pilot study. International Journal of Disability & Human Development: (5) 3:S. 53-59.
Weiner, D.K., Peterson, B., Ladd, K., McConnell, E.R.N., Keefe, F. (1999a). Pain in nursing home residents: An exploration of prevalence, staff perspectives and practical aspects of measurement. Clinical Journal of Pain; 15 (2): S. 92-101.
Weiner, D., Peterson, B., Keefe, F. (1999b). Persistent pain-associated behaviours in the nursing home: resident versus caregiver perceptions. Pain; 80: S. 577-588.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 32-33 (Teil II)

Zitat (Originalzitat):
"Zoals ook eerdere aangegeven heeft de American Geriatrics Society (AGS, 2002) de volgende kenmerkende gedragingen benoemd die typerende zijn voor chronische pijn bij ouderen met dementie.
Gezichtsuitdrukkingen
Verschillende gezichtsuitdrukkingen zijn karakteristiek voor de aanwezigheid van pijn, zoals het tonen van een grimas, het optrekken of neerlaten van de wenkbrauwen, de wangen optrekken, de oogleden toeknijpen, rimpelen van de neus, de hoeken van de lippen optrekken, kin omhoog duwen en het krullen van de lippen (Ekman et al, 1978; Hadjistavropoulos et al, 2002).
Verbalisaties en vocalisaties
Patiënten kunnen hun pijn op verschillende verbale manieren uiten, bijvoorbeeld: zuchten, kreunen, schreeuwen (Weiner et al, 1999b). Daarnaast benoemt de AGS (2002) ook vocalisaties zoals om hulp vragen of luidruchtig ademhalen.
Lichaamsbewegingen
Zowel mensen zonder als met cognitieve beperkingen kunnen fysieke beperkingen ervaren bij beweging. Ook kunnen bepaalde fysieke bewegingen op pijn wijzen zoals wanneer ouderen het pijnlijke gebied stevig omklemmen of wrijven (Weiner et al, 1999b). Bij ouderen kunnen 'guarding' en in mindere mate 'bracing' worden gebruikt om door beweging verergerde pijn op te sporen (Weiner et al, 1996; Hadjistavropoulos et al, 2000):

– ‘Guarding’ verwijst naar een abnormaal stijve of onderbroken beweging bij verandering van positie.
– ‘Bracing’ verwijst naar een stilstaande positie, waarin een volledig gestrekte ledemaat een abnormale verdeling van het gewicht gedurende minstens drie seconden handhaaft (The Australian Pain Society, 2005).
Verandering in interacties met anderen Onderliggende, soms niet geuite, pijn kan leiden tot de volgende gedragsveranderingen: agressie en terugtrekken. Dit geldt vaak bij cognitief beperkte patiënten met ernstige communicatieproblemen, die niet in staat zijn om pijn verbaal te rapporteren.
Verandering in activiteitspatronen of routines
Hierbij benoemt de AGS (2002) ook gewijzigde patronen zoals meer dwalen of voedsel weigeren. Daarnaast benoemen Weiner et al (1999b) patronen zoals op en neer lopen.
Verandering in geestelijke toestand: De AGS (2002) noemt hierbij bijvoorbeeld toename in verwarring.”

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
The Australian Pain Society (2005). Pain in residential aged care facilities: management strategies. The Australian Pain Society.
Ekman, P., Friesen, W. (1978). Investigator’s guide to Facial Action Coding System. Palo Alto: Consulting Psychologists Press.
Hadjistavropoulos, T., La Chapelle, D.L., Hadjistavropoulos, H.D., Green, S., Asmundson, G.J.G. (2002). Using facial expressions to assess musculoskeletal pain in older persons. Eur J Pain; 6 (3): S. 179-187.
Hadjistavropoulos, T., La Chapelle, D.L., Hadjistavropoulos, H.D., Green, S., Asmundson, G.J.G. (2002). Using facial expressions to assess musculoskeletal pain in older persons. Eur J Pain; 6 (3): S. 179-187.
Weiner, D., Pieper, C., Mc Connell, E., Martinez, S., Keefe, F. (1996). Pain measurement in elders with chronic low back pain: traditional and alternative approaches. Pain; 67: S. 461-467.
Weiner, D., Peterson,B., Keefe, F. (1999b). Persistent pain-associated behaviours in the nursing home: resident versus caregiver perceptions. Pain; 80: S. 577-88.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 21: Wie können diese Informationen gewonnen werden?

Seite: 36 (Teil II)

Zitat (Originalzitat):
“Het lichamelijk onderzoek en vaststellen van de oorzaak van pijn bij kwetsbare ouderen (zie deel 2, paragraaf 3.2.6)
3k) Lichamelijk onderzoek is nodig om behandelbare oorzaken van de pijn op te sporen. Lichamelijk onderzoek moet omvatten: algemeen lichamelijk onderzoek, onderzoek van de pijnlijke regio, spierskelet onderzoek, functioneel onderzoek, neurologisch onderzoek en evaluatie van het cognitief functioneren.”

Deutsche Formulierung der Empfehlung: Durchführung einer körperlichen Untersuchung und Feststellung der Ursache der Schmerzen bei „gebrechlichen“ Älteren.
3 k) Eine körperliche Untersuchung ist notwendig, um die Ursache von Schmerzen zu ergründen. Die körperliche Untersuchung sollte umfassen:
- Allgemeine körperliche Untersuchung
- Untersuchung der schmerzhaften Region
- muskuloskelettale Untersuchung
- Funktionelle Untersuchung
- Neurologische Untersuchung und
- Evaluation der kognitiven Fähigkeiten

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zie Hadjistavropoulos et al. 2007 Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Lynn Beattie, B., Chibnall, J.T., Craig, K.D., Ferrell, B., Ferrell, B., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S.J., Harrison, E.L., Katz, B., Keefe, F.J., Lieber, S.J., Lussier, D., Schmader, K.E., Tait, R.C., Weiner, D.K., Williams ,J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons Clinical Journal of Pain; 23 (Supplement): S. S1-S43.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

AGS 2002
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: S210

Zitat (Originalzitat): "A variety of verbal descriptor scales, pain thermometers, numeric rating scales, and facial pain scales have acceptable validity and are acceptable for many older adults. (…) (IIA)

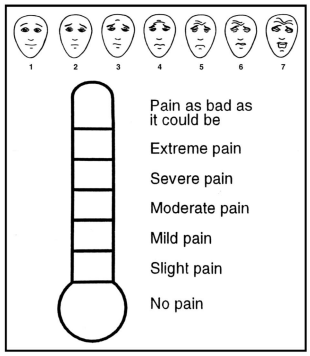

Figure 1. Samples of two pain intensity scales that have been studied in older persons. Directions: Patients should view the figure without numbers. After the patient indicates the best representation of their pain, the appropriate numerical value can be assigned to facilitate clinical documentation and follow-up. Source: The faces scale is adapted from Pain 1990; 41(2):139-150. With permission from Elsevier Science—NL, Sara Burgerhartstraat 25, 1055 KV Amsterdam, The Netherlands. The thermometer is adapted with permission from Keela Herr.

The use of a multidimensional pain instrument that evaluates pain in relation to other domains (e.g., the Pain Disability Index[43] or the Brief Pain Inventory[44]) should be considered. (IIB) "

Evidence-Grad: II
Empfehlungsstärke: A - B

Referenzen:
43. Tait, R.C., Chibnall, J.T., Krause, S. (1990). The Pain Disability Index: psychometric properties. Pain; 40: S. 171-182.
44. Cleeland, C.S., Ryan, K.M. (1994). Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore; 23: S. 129-138.

AMDA_2009_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Summary 2009 & Volltext 2012

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 3 (2012)

Zitat (Originalzitat):
"In another study, three easily-administered pain assessment scales (the visual analog scale, the behavior [faces] scale, and the pain descriptive scale) were shown to increase the frequency of pain diagnosis among nursing horne patients, even among those who were cognitively impaired.[12] Observational scales can also be used. In a study of pain prevalence in nursing horne patients with dementia using the observational scale PACSLAC-D, almost half of the patients were observed to experience some pain.[13]"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
12. Kamel, H.K., Phlavan, M., Malekgoudarzi, B. et al. (2001). Utilizing pain assessment scales increases the frequency of diagnosing pain among e1derly nursing horne residents. J Pain Symptom Manage; 21: S. 450-455.
13. Zwakhalen, S.M., Koopmans, R.T., Geels, P.J. et al. (2009). The prevalence of pain in nursing horne residents with dementia measured using an observational pain scale. Eur J Pain; 13: S. 89-93.

AMDA_2009_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Summary 2009 & Volltext 2012

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 9-10 (2012)

Zitat (Originalzitat):
“Assessing pain intensity. The ideal pain scale would be brief, combine descriptive and behavioral measurements of pain, require minimal staff training, and be valid across the range of cognitive and communicative abilities encountered in the LTC setting. No available pain scale, however, has one of these characteristics. Therefore, staff members need to determine which of the available tools best suits the individual patient' s cognitive status and communication abilities. Some patients will easily describe pain using a 0 to 10 numerical scale, whereas others may prefer the qualitative pain descriptors “none," "mild,” "moderate," or “severe." Patients with verbal difficulties may be able to identify pain intensity on a 0 to 10 linear scale or to identify on a pictorial scale which facial expression represents their pain state[26,27.] Still others may not have the cognitive capacity to communicate at all and will merely exhibit unusual or inappropriate behaviors as indicative of the presence of pain. Having determined which pain scale best suits the individual patient, document which scale is to be used and encourage all members of the interdisciplinary team to use that scale consistently to monitor the patient' s pain.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[26.] Wong, D.L., Baker, C.M. (1988). Pain in children: Comparison of assessment scales. Pediatr Nurs; 14: S. 9-17.
[27.] Bieri, 0., Reeve, R.A., Champion, G.D. et al. (1990). The Faces PainScale for the self-assessmentof the severity of pain experienced by children: Development, initial validation, and preliminary investigation for ratio scale properties. Pain; 41: S. 139-150:

AMDA_2009_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA).
Summary 2009 & Volltext 2012

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 10 (2012)

Zitat (Originalzitat):
“Herr et al[28] reviewed the use of tools that could be used for severe cognitive impairment and recommended the PAIN-AD (Pain Assessment in Advanced Dementia) and PACSLAC (Pain Assessment Checklist for Seniors with Limited Ability to Communicate) tools. The Abbey pain scale is another tool that can be used in patients who cannot verbalize.[29]Some literature suggests that elderly patients may prefer numerical pain scales presented vertically rather than horizontally.[30] The Iowa Pain Thermometer is one such tool.[31] “

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[28.] Herr, K., Bursch, H., Ersek, M. et al. (2010). Use of pain-behavioral assessment tools in the nursing horne: Expert consensus recommendations for practice. J Gerontol Nurs; 36: S. 18-29.
[29.] Abbey, L., Piller, N., Oe Bellis, A. et al. (2004). The Abbey pain scale: Al-minute numerieal indicator for people with end-stage dementia. Int J Palliat Nurs; 10: S. 6-13.
[30.] Herr, K.A., Mobily, P.R. (1993). Comparisonpf selected pain assessment tools for use with the elderly. Appl Nurs Res; 6: S. 39-46.
[31.] Herr, K., Spratt, K.F., Garand, L., Li, L. (2007). Evaluation of the Iowa pain thermometer and other selected pain intensity scales in younger and older adult cohorts using controlled c1inical pain: A preliminary study. Pain Med; 8: S. 585-600.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 4
Zitat (Originalzitat): “In the absence of an established instrument for this purpose, [Anm. ML: Informant Report] these management strategies use the Brief Pain Inventory[15] as a model for an informant report pro-forma, Informant Opinion of a Resident’s Pain (…) However, a recent Australian pilot study[17] suggests caution in interpreting the results of this kind of proxy rating due to poor correlation between such ratings and self-reporting and observational scales.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: 15. Cleeland, C.S. (1989). Measurement of pain by subjective report. In Chapman, C.R., Loeser, J.D. (ed.). Issues in pain measurement. New York: Raven Press. 17. Gibson, S.J., Scherer, S.C., Goucke, C.R. (2004). Preliminary field-testing and preparations for implementing Australian Pain Society and Australian Pain Relief Assoc Pain management guidelines for residential care Nov. www.apsoc.org.au/pdfs/APRA-finalreport7.doc

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 7
Zitat (Originalzitat): “The Resident’s Verbal Brief Pain Inventory (Table 8) is used as the standardized multidimensional pain assessment tool at the time of initial assessment (…) for residents with sufficient cognitive ability.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 7
Zitat (Originalzitat): “The Abbey Pain Scale (…) is the recommended pain assessment tool for residents with severe cognitive impairment.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 11

Zitat (Originalzitat):
"The Resident's Verbal Brief Pain Inventory (RVBPI) (…) is a modification of the Brief Pain Inventory (BPI)[16] (…) and has been designed and developed specifically for use in residential aged care facilities as part of these management strategies.
The original BPI is evidence-based and is known to be useful to assess the global impact of pain in older community populations [8] although there have been no previous formal validation studies for its use in residential aged care populations."

"The BPI was originally developed in English for the US and is now available in 36 languages, although only 17 of these have been properly validated (Appendix 4).
The RVBPI (The Resident's Verbal Brief Pain Inventory) takes into consideration evidence that most residents with moderate degrees of dementia prefer verbal descriptors of pain intensity, rather than numeric rating scales. One study [17] of a nursing home group with mild to moderate dementia found 65 per cent could complete a verbal descriptor scale while only 47 per cent could complete a numeric intensity scale. Accordingly, the RVBPI uses verbal descriptors to assess intensity of all variables. A pilot study [18] in Australian high-level and low-level care facilities suggests the RVBPI is useful, reliable and valid for this population.
However, even residents who can communicate effectively may understate pain (Table 1). The RVBPI may be less reliable in those with moderate cognitive impairment. In cases of borderline capacity to communicate it may be possible to enlist the support of a relative or carer for a joint pain report from both the resident and relative. In more severe dementia, when the report is largely the opinion of the relative, the Informant Opinion of a Resident's Pain (Table 3) should be used instead of the RVBPI in conjunction with an observational scale (see pg 14).
The RVBPI assesses the physical and psychosocial factors relevant to pain in appropriate detail. On average, it takes about seven minutes to administer.[18] The first question determines the need for further assessment. If the answer to the first question is no, then no further questions are indicated. Further questions evaluate pain intensity and the effectiveness of current treatments. A body map defines the site of pain. This is helpful in evaluating the cause of pain. The size of the area in which pain is felt, the shape (distribution) and travel path (radiation) of the pain also often suggest a certain cause (for example, sciatica).
Pain location also guides the effective application of local treatments. The remainder of the RVBPI looks at the impact of pain on activity, mood, mobility, socialisation and sleep."

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[8.] Herr, K.A., Garand L. (2001). Assessment and measurement of pain in older adults. In Ferrell, B. (ed.). Pain management in the elderly. Clinics in geriatric medicine. WB Saunders Company.
[16.] Cleeland, C.S. (1989). Measurement of pain by subjective report. In Chapman, C.R., Loeser, J.D. (ed.). Issues in pain measurement. New York: Raven Press.
[17.] Ferrell, B.A., Ferrell, B.R., Rivera, L.J. (1995). Pain in cognitively impaired nursing home patients. J Pain Symptom Manage; 10: S. 591-598.
[18.] Gibson, S.J., Scherer, S.C., Goucke, C.R. (2004).Preliminary fieldtesting and preparations for implementation of Australian Pain Society and Australian Pain Relief Association pain management guidelines for residential care. www.apsoc.org.au/pdfs/APRA-finalreport7.doc

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 13
Zitat (Originalzitat): “Numeric Rating Scale (NRS) Both horizontal and vertical versions of the verbally administered NRS are available. In using an NRS, the clinician simply asks the resident: "On a scale of zero to 10, with zero meaning no pain and 10 meaning the worst pain possible, how much pain do you have now?" An NRS is known to be reliable and valid in older populations.[8] The US Joint Commission on Accreditation of Healthcare Organizations and many other institutions have all adopted this method for routine assessment of "pain as the fifth vital sign" after observation of pulse, blood pressure, respiration rate and temperature. The 10-point NRS (…) is particularly useful for quantifying treatment response. (…)” “The vertical form of the scale (…) may be preferable for older people with impaired abstract reasoning skills.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: [8] Herr, K.A., Garand, L. (2001). Assessment and measurement of pain in older adults. In Ferrell, B. (ed.). Pain management in the elderly. Clinics in geriatric medicine. WB Saunders Company.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 13
Zitat (Originalzitat): “Verbal Descriptor Scale (VDS) Some older adults, whether or not cognitively impaired, may have difficulty responding to an NRS (as noted earlier in the RVBPI recommendation). For residents who prefer, and who have relatively good retention of verbal communication, a VDS may be more useful than an NRS. Various types of VDS have been validated. They ask people to respond to brief descriptions of levels of pain intensity such as those shown in the six-category VDS (…).” “Residents, with whom communication is adversely affected by linguistic or cultural backgrounds or limited education, may still be able to respond to a VDS.[8] (…) Question five from the RVBPI can also be extracted to serve as a more simple four-category VDS. “
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: [8.] Herr, K.A., Garand, L. (2001). Assessment and measurement of pain in older adults. In Ferrell, B. (ed.). Pain management in the elderly. Clinics in geriatric medicine. WB Saunders Company.

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 14

Zitat (Originalzitat):
"Non-Communicative Residents
A review of published studies of observational pain scales with evidence of utility for people with severe dementia living in residential aged care facilities led to an Australian study [18] that applied both the Abbey Pain Scale [20] and the Pain Assessment in Advanced Dementia (PAINAD) Scale [21] to a resident group.
Both of these behavioural observation scales were found to be a useful adjunct to verbal self-report and essential for those with dementia or verbal communication problems.
The Abbey Pain Scale showed marginally better utility, reliability and validity as well as greater acceptance from aged care staff.[18]
The Australian Pain Society's recommended assessment instrument for residents with whom verbal communication is not feasible and the RVBPI is not suitable is: The Abbey Pain Scale"

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[18.] Gibson, S.J., Scherer, S.C., Goucke, C.R. (2004). Preliminary fieldtesting and preparations for implementation of Australian Pain Society and Australian Pain Relief Association pain management guidelines for residential care. www.apsoc.org.au/pdfs/APRA-finalreport7.doc.
[20.] Abbey, J., Piller, N., Bellis, A., Esterman, A., Parker, D., Giles, L., Lowcay, B. (2004). The Abbey pain scale: a 1 minute numerical indicator for people with end stage dementia. Int. J. Palliative Nursing; 10: S. 6-13.
[21.] Warden, V., Hurley, A., Volicer, L. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. J Am Med Dir Assoc; 4: S. 9-15.

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 14-15

Zitat (Originalzitat):
"The Abbey Pain Scale (…) created for the measurement of pain in people with dementia who cannot verbalise. Based on observation and knowledge of a resident's usual function and medical history, the resident is rated on a four-point word descriptor scale (absent, mild, moderate, severe) across six domains of pain-related behaviour: vocalisation, facial expressions, change in body language, change in behaviour, physiological change and physical changes. Scores are combined to provide an overall assessment of pain intensity ranging from no pain to severe. Pain is also rated as being acute, acute on chronic or chronic. The Abbey Pain Scale takes between two and six minutes to administer.[18]
An alternative pain assessment instrument to the Abbey Pain Scale is the Pain Assessment in Advanced Dementia (PAINAD) Scale (…). It was found to have acceptable utility, validity and reliability in the Australian study.[18]"

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[18.] Gibson, S.J., Scherer, S.C., Goucke, C.R. (2004). Preliminary fieldtesting and preparations for implementation of Australian Pain Society and Australian Pain Relief Association pain management guidelines for residential care. www.apsoc.org.au/pdfs/APRA-finalreport7.doc.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 16
Zitat (Originalzitat): “Residents with borderline communicative capacity (…). There will be many residents who can provide some pain report but whose severity of cognitive impairment reduces the reliability of the report (…). These residents will be best managed, at least initially, by applying both verbal and observational sets of assessment procedures. Preliminary Australian research[18] found both the Abbey and PAINAD behavioural observation scales were a useful adjunct to verbal self-report. Experience over time may indicate whether one set of procedures can be ceased in favour of the other for a particular individual.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: [18.] Gibson, S.J., Scherer, S.C., Goucke, C.R. (2004). Preliminary fieldtesting and preparations for implementation of Australian Pain Society and Australian Pain Relief Association pain management guidelines for residential care. www.apsoc.org.au/pdfs/APRA-finalreport7.doc.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 16
Zitat (Originalzitat): “Alternative instruments Other pain assessment instruments not yet referred to in these management strategies include: Communicative Residents - Uni-dimensional pain intensity scales for pain intensity assessment only. These include the: - Visual Analogue Scale (…) - Pictorial or Faces Pain Scale (…) - Alternative review instruments include the: - Memorial Symptom Assessment Scale (…) - Memorial Pain Assessment Card (…) - Geriatric Pain Assessment Sheet (…) Non-Communicative Residents - The Checklist of Nonverbal Pain Indicators (…)”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 8
Zitat (Originalzitat): “Some older people may be more willing to score pain on a pain intensity rating scale than say they have pain[21]. Intensity rating scales can enhance the detection of pain in nursing home residents[22, 23, 30].“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [21.] Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patients. Aging Clin Exp Res; 12: S. 380-7.

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 13–14

Zitat (Originalzitat):
“i. Intensity of pain
Evidence based statement
Verbal Rating / Descriptor Scales and Numerical Rating Scales best quantify the intensity of pain in older people with no cognitive impairment and in those with mild to moderate cognitive impairment. The “Faces Scale” is less effective in older people than Verbal Descriptor Scales or Numerical Rating scales. Visual Analogue Scales (VAS) are the least effective method for measuring the intensity of pain in older people. (…)”
“Recommendations
Use a simple Verbal Rating or Numerical Rating Scale in routine practice to asses and monitor the intensity of pain and response to treatment. (…)
Choose a standardised intensity scale to suit each individual person and continue to use this for sequential assessment in that individual.
Scales should use large clear letters/numbers, using black and white rather than mid-tones and be presented under good lighting.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen
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45. Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Lynn Beattie, B., Chibnall, J.T., Craig, K.D., Ferrell, B., Ferrell, B., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S.J., Harrison, E.L., Katz, B., Keefe, F.J., Lieber, S.J., Lussier, D., Schmader, K.E., Tait, R.C., Weiner, D.K., Williams, J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons Clinical Journal of Pain; 23 (Supplement): S. S1-S43.
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47. Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults. Clinical Journal of Pain; 20 (4): S. 207-19.
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49. Stolee, P.,Hillier, L., Esbaugh, J., Bol, N., McKellar, L., Gauthier, N. (2005). Instruments for the Assessment of Pain in Older Persons with Cognitive Impairment Journal of the American Geriatrics Society; 53 (2): S. 319-326
50. Gagliese, L., Katz, J. (2003). Age differences in postoperative pain are scale dependent: a comparison of measures of pain intensity and quality in younger and older surgical patients. Pain; 103: S. 11-20.
51. Herr, K.A., Mobily, P.R., Kohout, F.J., Wagenaar, D. (1998). Evaluation of the Faces Pain Scale for use with the elderly. The Clin J Pain; 14: S. 29-38.
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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 16–17

Zitat (Originalzitat):

“iv Tools for the multidimensional assessment of pain

Evidence based statement

There is no evidence that any one multi-dimensional assessment tool is better than another (…)”

“The McGill Pain Questionnaire (MPQ) is a standardised scale for the assessment of pain in cognitively intact adults. It assesses the sensory, affective and evaluative dimensions of pain[69]. Evaluation of the psychometric properties of the scale in a sample of young and older people supports its use in older people[26]. However concerns persist about the time required for completion, with regard to application in a busy clinical setting[70] and also, patients’ abilities[50]. As the short form of the MPQ is reported as performing equally as effectively as the long version, its simpler format may be preferred for use with frail older people[71, 72].

The Geriatric Pain Measure (GPM)[73] is a 24 item multi-dimensional pain assessment tool designed for use with older people. It has been successfully tested for validity and reliability in subjects attending ‘ambulatory geriatric clinics’, but does not appear frequently in subsequent research. Recently a modified version has been used in cognitively impaired adults[74]. Items on the GPM reflect the multiple dimensions of pain including pain intensity, pain on activity, the impact on mood and independence.

The Brief Pain Inventory (BPI) can also be considered as part of a multidimensional

assessment of pain in older people. It consists of 15-items that assess severity of pain, interference of daily activities due to pain, and impact of pain on mood and enjoyment of life. Its psychometric properties have been favourably evaluated in a sample of people with arthritis and low back pain sufferers, including but not specific to, older people[75]. “

Recommendations
“All older people in whom pain is detected should have a clinical assessment of the multi-dimensional aspects of pain including:
A sensory dimension which describes the intensity and nature of pain e.g. crushing, sharp.
An affective/evaluative dimension which describes the emotional component of pain and how pain is perceived (e.g. dangerous, exhausting, frustrating, frightening)
The impact on life including physical, functional and psychosocial effects.
Health care professionals should familiarise themselves with relevant assessment tools and use them routinely. Assessors should consider the use of one tool or a combination of tools to assess the differing dimensions of pain.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 18

Zitat (Originalzitat):
“A systematic review of 18 self-report instruments in patients with cognitive impairment found very variable completion rates for instruments that require individuals to discriminate between adjectives or numbers corresponding to adjectives (Verbal Rating / Descriptor Scale, Memorial Pain Assessment Scale). Completion rates are highest for instruments assessing the intensity dimension of pain (e.g. Pain Thermometer, Numerical Rating Scale). None of the self-report instruments demonstrated excellent reliability or validity[49].
Of the non-verbal scales, Faces Pain Scale (60%) and Facial Affective Scale (50%) were poorly understood in patients with early Alzheimer’s Disease (AD) and very poorly understood in mid-stage AD (30% and 70%)[76]. The Coloured Visual Analogue Scale was understood by 100% patients with early AD and 80% with mid stage AD[76], and it has been

recommended in the consensus paper by Hadjistavropoulos 2007[45].
In a study of 130 long-term care residents in Canada, only 24% mildly cognitively impaired and 11% moderately cognitively impaired subjects put the faces of the Faces Pain Scale in correct order[48]."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[45.] Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Lynn Beattie, B., Chibnall, J.T., Craig, K.D., Ferrell, B., Ferrell, B., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S.J., Harrison, E.L., Katz, B., Keefe, F.J., Lieber, S.J., Lussier, D., Schmader, K.E., Tait, R.C., Weiner, D.K., Williams, J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons Clinical Journal of Pain; 23 (Supplement): S. S1-S43.

[48.] Kaasalainen, S., Crook, J. (2004). An exploration of seniors ability to report pain. Clinical Nursing Research; 13 (3): S. 199-215.

[49.] Stolee, Paul PhD' Hillier, Loretta M. MA*; Esbaugh, Jacquelin MA; Bol, Nancy MScN; McKellar, L., Gauthier, N. (2005). Instruments for the Assessment of Pain in Older Persons with Cognitive Impairment Journal of the American Geriatrics Society; 53 (2): S. 319-326.

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 18–20

Zitat (Originalzitat):

Observational assessment of pain

"In the presence of cognitive impairment, behavioural measures of pain can be used with moderate to reasonable interrater reliability, but even in cognitively intact older adults they are not a good measure of intensity[77].

Several systematic reviews have recently reviewed behavioural pain assessment tools for use in non-verbal older adults and older adults with dementia[35,49,78.] Results indicate that behavioural pain assessment tools are still in the early stages of development and evaluation. Reliability and validity data are limited or still unavailable for many instruments.

The Discomfort Scale-Dementia of Alzheimer Type (DS-DAT) was developed and evaluated in nursing home residents in whom the tool had reasonable reliability and validity. Significant increases in scores were noted during fever[79].

However, the administration and scoring of DS–DAT is quite complex and requires considerable training. There are no observations of the patient during activity which is a further limitation of this particular tool.

The Abbey Pain Scale, developed for end-stage dementia, was built on the DS-DAT and used the Delphi technique across experts from the US and Australia to identify parameters. It was piloted in 52 residents, modified and evaluated in 61 residents. Internal consistency reliability was reasonable (Cronbach's alpha 0.74), but interrater reliability poor[80].

The PAINAD Scale is a simple 5 item observational tool, developed and validated in 19 residents with advanced dementia[81]. Validation studies have confirmed the potential for this scale[82]. The PAINAD covers only a limited number of non-verbal pain behaviours. It is short and easy to use but it needs to be evaluated more widely to assess its sensitivity for pain in clinical settings, as it doesn't appear to be comprehensive.

The Pain Assessment Check List for Seniors with Severe Dementia (PACSLAC) includes a total of 60 items covering subtle as well as common pain behaviours. The tool appears comprehensive and yet easy to use with good internal consistency[83]. A recent prospective

evaluation in Dutch nursing home residents revealed good validity and reliability, and nurses considered it easy to use[84].
The NOPAIN tool involves observing patients' pain behaviours (verbalisation, vocalisation, face, bracing, rubbing and restlessness) during activities of daily living such as bathing and dressing[85]. The tool has been evaluated in the US and interrater reliability and construct validity appear to be reasonable. Herr et al felt that the tool shows promise in that it appears easy to use but it is not very comprehensive so further evaluation in clinical settings is needed[35].
DOLOPLUS 2 is a French tool developed for the multidimensional assessment of pain and includes items covering somatic, psychomotor and psychosocial reactions to pain[86]. The French version has been evaluated in several clinical settings and appears to have reasonable internal consistency, interrater reliability and test-retest reliability. However there has been a very limited evaluation of this tool in English and there may therefore be translation issues. It needs to be evaluated further in English speaking populations and this is currently underway.
All these instruments include different combinations of observations which are potentially indicative of the presence of pain[35,87]. Seven main types of observation occur within these pain assessment tools:
1. Physiological observations e.g. breathing pattern, sweating
2. Facial expressions e.g. wincing, grimacing, frowning, rapid blinking.
3. Body movements e.g. guarding, altered gait, pacing, rocking, hand wringing, repetitive movements.
4. Verbalisations / vocalisations e.g. moaning, groaning, asking for help, screaming, aggressive or offensive speech.
5. Changes in interpersonal interactions e.g. aggression, withdrawal, resisting care.
6. Changes in activity patterns or routines e.g. wandering, altered sleep pattern, altered rest patterns.
7. Mental status changes e.g. crying, tears, increased confusion, irritability.
There is as yet no single instrument that has been shown to have psychometric properties sufficient for it to be recommended for general clinical use. Detailed critiques can be found elsewhere[35,49,78.].
As indicators of pain, these observations/ behaviours will vary substantially between individuals. Familiarity with patients, together with information from carers about the significance of certain behaviours, should help clinicians to interpret them. We recommend that carers become familiar with these behaviours/observations in their patients and monitor carefully so that alterations in behaviour/observations are detected promptly. The presence of observational indicators of possible pain should prompt a more detailed clinical assessment. "

Recommendations

"In older people with cognitive impairment or with difficulty in communication, observational assessment becomes essential for assessing the presence of pain.
Carers familiar with older people with cognitive impairment should be included in the assessment of their pain."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

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Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 106

Zitat (Originalzitat):
"Research suggests that simple self-report procedures are appropriate for use with a large percentage of people with mild to moderate dementia. Specifically, Ferrell et al.30 investigated the percentage of residents in longterm care facilities who were capable of completing various unidimensional self-report scales (e.g., a numeric rating scale ranging from 0 to 10 (Ferrel et al, 1995; Chibnall & Tait; 2001) or a 100 mm horizontal visual analogue scale (Gagliese & Katz, 2003; Gagliese et al. 2005; Herr & Mobily, 1993; Herr et al, 2004)"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–86.
Ferrell, B.A., Ferrell, B.R., Rivera, L. (1995). Pain in cognitively impaired nursing home patients. J Pain Symptom Manage; 10: S. 591–598.
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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 106

Zitat (Originalzitat):
"Cognitive status was assessed using the Modified Mini-Mental Status Examination (MMSE) (Folstein et al, 1975) (…) a widely used measure of cognitive function; the average MMSE score of the participants was 12.1/30 (see Tombaugh and McIntyre[37] for detailed information on MMSE cutoff scores). Weiner et al.(1998) evaluated a numeric 0–10 pain scale[30,31] and a pain thermometer; they found that older adults with dementia who could comprehend a 0–10 pain assessment scales had MMSE scores ranging from 18 to 22 (of a possible 30), whereas those who had major difficulties comprehending the scale tended to have MMSE scores closer to 13/30.[b] Similarly, Chibnall and Tait (2001) demonstrated that seniors with an average MMSE score of 18 tended to provide valid responses on the 21-point box scale (reviewed below).[31] …. Based on the studies by Weiner et al.,[38] Chibnall and Tait,[31] and other related research, a rule of thumb for assessing the likelihood that older adults with cognitive impairments can self-report pain is that those who score 18 or higher on the MMSE are typically capable of providing valid self-report, whereas persons with scores of 13 or lower are least likely to provide valid reports.[16]"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–86.
Ferrell, B.A., Ferrell, B.R., Rivera, L. (1995). Pain in cognitively impaired nursing home patients. J Pain Symptom Manage; 10: S. 591–598.
Folstein, M.F., Folstein, S.E., McHugh, P.R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. J Psychiatr Res; 12: 189–98.
Hadjistavropoulos, T. (2005). Assessing pain in older persons with severe limitations in ability to communicate. In: Gibson, S.J., Weiner, D. (ed.). Pain in the elderly. Seattle: IASP Press: S. 135–51.
Tombaugh, T.N., McIntyre, N.J. (1992). The mini-mental state examination: a comprehensive review. J Am Geriatr Soc; 40: S. 922–935.
Weiner, D.K., Peterson, B.L., Logue, P., Keefe, F.J. (1998). Predictors of pain selfreport in nursing home residents. Aging; 10: S. 411–420.

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 106-108

Zitat (Originalzitat):
"Coloured Analogue Scale (CAS) The CAS is a self-report scale used to measure pain severity. It is usually made of hard plastic and resembles a thermometer. The colour of this specific type of visual analogue scale changes gradually from the bottom to the top; the bottom is thin and white in colour (representing no pain), and the top is thicker in size and red in colour (representing extreme pain). Participants are asked to use a horizontal sliding bar to indicate their level of pain. The location of the bar corresponds to a numeric rating (ranging from 0 to 10) on the back of the scale. In a study examining self-report measures for use in older adults, the CAS was found to be interpreted correctly by all cognitively intact seniors as well as by seniors with mild dementia.[41] Moreover, the CAS was correctly interpreted by 80% of seniors with moderate dementia, suggesting that it is appropriate for use with many older adults with cognitive impairments.[41] However, there is also evidence to suggest that responses to the CAS tend to become invalid as the severity of dementia increases. [23] Verbal

Rating Scales (VRS) [32, 33, 35, 38, 42, 43] Verbal rating scales, or verbal descriptor scales, are self-report scales that require the individual to choose the descriptor that best matches his or her level of pain—for example, no pain, slight pain, mild pain, moderate pain, severe pain, extreme pain, and pain as bad as it could be. Each of these descriptors corresponds to a number, often found on the back of the scale, with higher numbers corresponding to more intense descriptors of pain. Research comparing five different selfreport measures, including a simple VRS, suggests that simple VRS are appropriate measures of pain intensity in cognitively intact older adults as well as in older adults with mild dementia.15 Moreover, research has demonstrated that the VRS ranked higher than various numeric and/or visual analogue scales (see below) for both younger and older adults in terms of scale success, internal consistency, reliability, sensitivity, and preference.35 Numeric Rating Scales (NRS)[30,31,33,35,38,44] Numeric rating scales are measures of pain intensity that are available in a number of ranges (e.g., 0–5, 0–10, 0–100), with 0 representing no pain and the highest number on the scale indicating pain as bad as it could be. Participants completing an NRS are asked to choose the number that best represents the intensity of their pain. Research studies employing NRS suggest that they are appropriate for use among cognitively intact seniors as well as seniors with mild to moderate dementia.[15,38] NRS have also been shown to be more reliable than VRS, particularly in patient populations with a lower educational level.[45] [21] -Point Box Scale[46] The 21-point box scale is a horizontal scale consisting of 21 boxes containing numbers ranging from 0 (indicating no pain) to 100 (indicating pain as bad as it could be). The numeric ratings on the 21-point box scale increase in increments of five. To complete the scale, individuals are asked to place an x on the number that best represents the intensity of their pain. The 21-point box scale is easy to administer, as it does not rely on verbal descriptors of pain.[47] In an empirical investigation of four self-report scales in seniors with and without dementia, the 21-point box scale was found to be the best all-around measure.31 Visual Analogue Scales (VAS)[32–35,48] These scales are vertical or horizontal lines, typically 10 cm in length, anchored by two verbal descriptors of pain (e.g., no pain and pain as bad as it can be). Participants are asked to mark an x on the line at the point corresponding to their level of pain. VAS are scored by measuring the distance between the beginning of the scale and the point indicated by the participant; this distance is then translated into a pain-intensity score (e.g., a participant who places a mark 4.5 cm from the beginning of the scale would have a pain-intensity score of 4.5). Although some researchers have obtained encouraging validity results for vertical VAS,[29,49] others have recommended against the use of VAS in general because they observed unusually high numbers of unscorable responses with older adults.[50]"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Zu 1) CAS:
Hadjistavropoulos, T., Craig, K.D., Martin, N., Hadjistavropoulos, H.D., McMurty, B. (1997). Toward a research outcome measure of pain in frail elderly in chronic care. Pain Clinic; 10: S. 71–79.
Scherder, E.J., Bouma, A. (2000). Visual analogue scales for pain assessment in Alzheimer's disease. Gerontology; 46: S. 47–53.
2) Zu Verbale Rating Skala:
Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1–S.43.
Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults: use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clin J Pain; 20: S. 207–219.
Zu 3) NRS:
Ferraz, M.B., Quaresma, M.R., Aquino, L.R., Atra, E., Tugwell, P., Goldsmith, C.H. (1990). Reliability of pain scales in the assessment of literate and illiterate patients with rheumatoid arthritis. J Rheumatol; 17: S. 1022–1024.
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Weiner, D.K., Peterson, B.L., Logue, P., Keefe, F.J. (1998). Predictors of pain selfreport in nursing home residents. Aging; 10: S. 411–420.
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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 108-110

Zitat (Originalzitat):
OBSERVATIONAL MEASURES OF PAIN
"Ideally, best clinical practice in pain assessment would involve valid self-report information supplemented by clinical observations of pain behaviour. However, in cases where valid self-report is unavailable, reliance on observation of nonverbal pain behaviours is essential. …. Several reviews of these tools have been published,[15,16,52,53] and, based on these, among the most promising observational pain assessment tools to date are the Abbey Pain Scale,54 the Pain Assessment in Advanced Dementia Scale (PAINAD),[55] the DOLOPLUS-2,[56] and the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC).[57]
The Abbey Pain Scale is a brief, six-item scale that takes a knowledgeable caregiver only a few minutes to complete. Items of the APS measure aspects of the pain experience including physiological changes (e.g., change in temperature), vocalization (e.g., whimpering), and facial expressions (e.g., grimacing). Items are scored on a scale ranging from 0 (absent) to 3 (severe). An important caveat regarding the APS is that it is designed to measure change in these behaviours over time; as such, it must be completed by someone familiar with the

patient. This may limit the utility of this tool, particularly in acute-care settings. Despite this limitation, however, the scale has been shown to be internally consistent, and scores on the APS have been found to decrease significantly following pain intervention by nurses. (It should be noted that the nurses completing the scale were not blind with respect to whether or not an intervention had been administered.54) Items on this scale cover five of the six AGS-recommended domains (facial expressions, verbalizations and vocalizations, changes in activity patterns and routines, and body movements); the ''behavioural change'' item covers, to some extent, the sixth AGS-recommended domain (mental status changes).

The Pain Assessment in Advanced Dementia Scale (PAINAD)55 The PAINAD is a five-item measure with item scores ranging from 0 to 2. These numeric ratings have different descriptors for each item of the PAINAD; for the item ''consolabity,'' for example, ratings are ''0 ¼ no need to console; 1 ¼ distracted or reassured by voice or touch; 2 ¼ unable to console, distract or reassure.'' The PAINAD takes, on average, less than 5 minutes to complete.[58] Examples of items measured by the PAINAD are negative vocalization and body language. The PAINAD has demonstrated moderate correlations with other measures of pain behaviour.[55] In addition, research involving the PAINAD supported its ability to discriminate between pain-related and non-pain-related situations;59 however, in the original study it had low internal consistency. [55] The PAINAD clearly covers three of the six AGS-recommended pain assessment domains (body movements, verbalizations and vocalizations, and facial expressions). Additional items of this tool focus on breathing patterns and consolability (which is related to the AGS-recommended domain of interpersonal interactions).

The DOLOPLUS-2 is a 10-item measure that includes somatic, psychomotor, and psychosocial domains. The DOLOPLUS-2 requires only a few minutes for a knowledgeable caregiver to complete. Each item of this scale is scored on a four-point scale ranging from 0 (behavior not present or abnormal for the individual) to 3 (significant behavioural disturbance). Examples of DOLOPLUS-2 items are ''protecting sore areas,'' ''mobility,'' and ''behaviour problems.'' Total scores on the DOLOPLUS-2 range from 0 to 30, and scores of 5 or higher are suggested to indicate pain. However, an important caveat is that DOLOPLUS-2 scores do not represent the level of pain at a particular moment but, rather, reflect the experience of pain over time.60 One important limitation of the DOLOPLUS-2 is that is must be completed by individuals who are familiar with the patient because some items measure change over time. It may therefore be of limited use for patients in acute-care settings. Items of the DOLOPLUS-2 have been found to be adequately correlated with one another, and it has been suggested that an abbreviated version of the DOLOPLUS-2 performs similarly.[61] The measure correlates moderately with self-reports on VAS and has adequate overall psychometric properties.[61] It covers five of the six AGS-recommended behavioural pain assessment domains (verbalizations and vocalizations, changes in activity patterns and routines, changes in interpersonal interactions, facial expressions, and body movements).

The PACSLAC is a 60-item checklist of pain behaviours wherein each behaviour present is scored as one point. Examples of behaviours included in the PACSLAC are grimacing, fidgeting, agitation, and shaking/trembling. Although the PACSLAC is divided into separate subcategories (e.g., facial expressions, activity/body movements), the developers recommend57 that only the total score be interpreted, because it tends to be more reliable than sub-scale scores. Despite being the longest and most comprehensive of the behavioural observation tools, the PACSLAC can be completed in approximately 5 minutes after minimal training. The PACSLAC has demonstrated very good psychometric properties and clinical utility, both in its initial validation and in prospective validation research.[57,62] A prospective validation study found that patients whose pain was being monitored using the PACSLAC experienced better management of their pain (through increased pro re nata [prn] pain medication use). Nonetheless, we note as a precaution that medication regimens for older adults should be evaluated on a regular basis, using the Beers criteria,[63] and that increased medication usage is not necessarily the optimal clinical practice for every patient. The PACSLAC has been translated into French (PACSLAC-F) and Dutch (PACSLAC-D).[60,64] In a study by Zwakhalen et al.,[60] nurses were asked to rate pain behaviours using the PACSLAC and two other observational measures of pain (the DOLOPLUS-2 and the PAINAD). Results indicated that all three observational measures of pain had adequate to

good psychometric properties; however, the PACSLAC was rated by nurses as the most clinically useful tool for assessing pain in seniors.[60] Moreover, Fuchs-Lacelle et al.[62] found that nurses who regularly used the PACSLAC to assess patients' pain demonstrated reduced stress and burnout levels relative to nurses completing an irrelevant checklist, presumably because when pain was better managed, residents were less agitated. The PACSLAC covers all six of the AGS-recommended pain-assessment domains."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

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Zu 4) PACSLAC

Fuchs-Lacelle, S., Hadjistavropoulos, T. (2004). Development and preliminary validation of the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC). Pain Manag Nurs; 5: S. 37–49.

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: S3

Zitat (Originalzitat):
“Although the primary focus of the clinical practice should dictate the choice of measures, it is fundamental to select psychometrically-sound measures that are reliable, valid, and sensitive enough to detect subtle change, such as the effects of common treatment interventions.
Whenever possible, measures chosen should have been developed or standardized in older adults, should be time efficient, and should not present an excess burden on the patient. Standardized performance-based measures and self-report measures augment the customary assessments performed by clinicians because they include constructs that range from the basic components of function to role function,[101] much of which is not routinely addressed by many clinical specialties, but is essential when evaluating patients with chronic pain conditions.”

“10 Where brief assessment tools are needed, the VDS and the NRS are, generally, recommended for the assessment of pain intensity among seniors who are cognitively intact and can self-report.
11 Where a more detailed self-report assessment of functional impact is possible, the BPI[134] or the GPM[167] should be considered. For detailed assessment of pain qualities, the MPQ[127] should be used for cognitively intact, literate older people. “

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: S4 – S5

“ 3 The CAS,[155,156] the 21-point box scale[151] or NRS and the VDS should be attempted with seniors whose cognitive functioning ranges from intact to mildly or moderately impaired. The FPS is an alternate tool that is preferred by some older persons, particularly African Americans and Asians.”

“4 At this point, assessment scales are under development and consensus could not be reached regarding the definitive recommendation of any particular scale. The PACSLAC[165] seems to be a promising tool for assessing pain among persons with cognitive impairments. Nonetheless, more research regarding the psychometric properties of this tool is needed. Although the initial psychometric findings are encouraging, the scale should be used with caution until additional data become available. Among the shorter instruments, the Doloplus 2[179] seems to be promising. Further research undertaking a direct comparison of various observer rated scales is needed to identify the relative strengths and weaknesses of currently available tools”

“9 Several instruments contain items that need to be assessed over time (eg, changes in sleeping, eating). With the possible exceptions of the PADE[183] and the NOPPAIN,[178] this

should not preclude their use in primary care settings because the health care provider may solicit the assistance of caregivers in completing these tools."

"Recommendations for Functional assessment (S. 4)
3. The most strongly recommended brief self-report index of function is the FSI.[222] The HAP[198] is also recommended because it measures current and previous activity participation and has been found to be particularly useful with older adults with chronic pain.
4. The Physical Performance Test (PPT) is strongly recommended as a performance-based measure of function because it tests both upper and lower body function.[216]
5. Gait speed (eg, Timed ''Up and Go'') and/or the Short Physical Performance Battery are recommended as measures of general mobility performance because of their strong predictive validity for disability and mortality.[44,45]"

"Recommendations for the Assessment of Emotional Functioning (S. 5)
6. At minimum, evaluation of emotional function in chronic pain patients should include an assessment of depression and a brief probe of preferred strategies for coping with pain. The GDS273 is well-validated and simple enough to be used with persons with mild to moderate dementia.[274,275]
7. Assessment of anxiety and pain-related anxiety is also recommended. The Beck Anxiety Inventory[287] and the Pain Anxiety Symptoms Scale[292] are brief and have been used with seniors although separate norms may be needed for the interpretation of scores obtained by older men.[299]
8. More comprehensive evaluation of emotional and psychosocial function in the context of chronic pain should also include assessment of (a) generalized perceived control or, alternatively, of control-relevant personality traits (eg, neuroticism) (b) pain-relevant cognitions and beliefs, and (c) social support with respect to any pain-relevant physical functional impairments as well as emotional support and including specific evaluation of how the patient's spouse or significant other responds to pain complaints."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 32

Zitat (Originalzitat):
"Most standard coping indices tend to be quite length y, presenting a problem for use in clinical settings. Jensen and Baron[52] offered substantially reduced versions of severa l pain-sp ecific co ping scale s. Although further validation of these ''short-form'' measures is needed, Jensen et al's analys es suggest that the 16 item-version of the Chronic Pain Coping Inventor y (CPCI), which has been used success fully among older adults [138,261] may be a good place to start. This instrument has demonstrated excellent internal consistency when used among older adults. [262]"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 14

Zitat (Originalzitat): "A Structured Pain Interview that includes simple questions related to presence and absence of pain or discomfort, pain intensity, frequency, location, and impact on daily activities, is a feasible approach to pain assessment even among patients with cognitive impairments.[104–106]"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 15-21

Zitat (Originalzitat): „S15 –S21“

Table 11. Pain Intensity Tools for Older Adults

Name of Measure	Description of Measure	Reliability	Validity/Utility	Limitations
Numeric Rating Scales (NRS) [106,112,114,115,151,158,176,301–311]	Available in a variety of scale ranges and anchors, including 0-5, 0-10, 0-20, and 0-100 scale, with 0 no pain and 5 (10, 20,100) most intense pain imaginable	- High internal consistency (Cronbach a 0.86-0.88) - Adequate test-retest reliability (r=0.57-083), decreased in those with cognitive impairment	- Has been tested in acute care, subacute care, pain clinic, long-term care, assisted living facility, and community dwelling - Strong positive correlation with other pain intensity scales - Sensitive to change in pain - Validated in white and African American samples - Preferred by many older adults	- Verbal version may be difficult for older persons with cognitive impairment - Requires abstract thought - Some older adults (with and without cognitive impairment) have difficulty with the scale - A smaller number orientation (0-5) may be less demanding and more effective in those with cognitive impairment; however, testing of this configuration is limited
Verbal Descriptor Scales (VDS) [112–115,126,127,129,151,158,176,301–306,309,311–313]	Available in a variety of scale types, including scales with Verbal Rating Scales (from 4 to 7 point options), Pain Thermometer, Present Pain Intensity (PPI) index, and Graphic Rating Scale	- High internal consistency (Cronbach a 0.85-0.86) - Adequate test-retest reliability (r=0.52-0.83), decreased in those with cognitive impairment	- Has been tested in acute care, subacute care, pain clinic, long-term care, assisted living facility, and community dwelling - Strong positive correlation with other pain intensity scales - Validated in white and African American samples - Preferred by older adults, low failure rate even in cognitively impaired - Thermometer adaptation may assist with understanding of tool - Adequate for use in clinical setting but sensitivity not sufficient for research purposes	Requires abstract thought - Unequal intervals between response categories - Limited number of response categories - Language demands greater
Facial Pain Scales [115,151,157,176,301–306,309,312–317]	Two main facial pain scales tested with older adults: - Faces Pain Scale (FPS) consists of seven faces (0-6) ranging from a neutral face (no pain) to a grimacing face (worst pain). It was revised to 6 faces as FPS-R to make it suitable with 0-10 scale - Wong-Baker FACES Scale consists of six faces ranging from a smiling face (no pain) to a face with tears (worst pain)	- High internal consistency (Cronbach a 0.88-0.89) - Acceptable to high test-retest reliability (r=0.44-0.94), decreased in those with cognitive impairment	- Has been tested in acute care, subacute care, pain clinic, long-term care, assisted living facility, and community dwelling - Less strong positive correlation with other pain intensity scales - Validated in white, African American, and Spanish, the FPS was preferred by many older adults, most preferred by African American and Spanish older adults - Does not require language, facilitating transcultural pain studies	- May assess a broader construct of pain affect rather than pain intensity - Requires abstract thinking and has been difficult for some older adults with cognitive impairment to use - Unequal intervals between response categories - Limited number of response categories
Visual Analog Scale (VAS) [114,115,126,129,302,305,306,308,310–312,315]	- A vertical or horizontal 100mm line anchored by verbal descriptors such as ‘‘no pain’’ and ‘‘worst pain possible.’’ Patients make a mark on the line that represents their pain intensity	- High internal consistency (Cronbach a 0.87-0.88) - Adequate test-retest reliability (r=0.75-0.83)	- Has been tested in acute care, pain clinic, long-term care, and community dwelling - Strong positive correlation with other pain intensity scales - Continuous variable enhances use for research	- Less preferred by many older adults - High failure rate - Requires use of paper/pencil or mechanical device, extra step in scoring which is more time-consuming and adding

			- Highly sensitive to change in pain intensity	additional source of error - Requires greater abstract thought
Philadelphia Geriatric Center Pain Intensity Scale (PGC-PIS)[116,230,315,318]	- Six items tapping experienced pain over the past several weeks, at the present moment, at its least and at its worst, number of days per week that the pain is ''really bad,'' and the extent to which pain interferes with daily activities - All but the ''days per week'' item were rated on 5-point scales (range 1=not at all to 5=extremely). A composite pain intensity measure was calculated by converting the ''days per week'' to a 5-point scale and averaging across all six items - Scoring 2 or more are considered to have pain	- Excellent internal consistency (Cronbach a 0.84-0.91) - Good test-retest reliability (r=0.84)	- Correlated well with the NRS (Spearman r =0.68) - Adequate reliability and validity for use with patients with dementia - Correlation between caregiver and care recipient pain report was stronger than for other pain measures examined	

TABLE 12. Multidimensional Pain Tools for Use With Older Adults

Name of Measure	Description of Measure	Time to Complete	Reliability	Validity/Utility	Limitations
SF-MPQ[128,129,131–133,319–321]	15 pain quality words scored on a 4-point Likert severity scale, plus a VAS for average pain intensity and a PPI for current pain	Not specified but likely 5-10 min	Inadequate to adequate internal onsistency (Cronbach a .41-0.98)	Factor structure supported for pain sensory, affective dimension	Not recommended for illiterate and cognitively impaired persons
	Dimensions: sensory and affective		High test-retest reliability for the total, sensory, affective, and average pain scores (ICC 0.88-0.96) but lower ICC of 0.75 for current pain scores	Suited for population in community dwelling and acute care	May not discriminate between pain types
				Reliable and valid for older adults	Not sufficiently validated with seniors whose language is other than English
Functional Pain Scale (FPS)[133]	0-5 scored tool that combines pain severity and function and rates tolerability of activity	Less than 1 minute	_ Interrater reliability >0.95	Validity testing showed high or quite acceptable correlations with other scales(r=0.62-0.90)	Limited by indicators included in the tool with interference based on ability to watch TV, read, and use telephone
	Dimensions: intensity and function			Responsiveness was superior to the other instruments tested	
				Suited for population in the community setting	
				Short and easy to use	
Pain Disability Index (PDI)[135,322–325]	7-item inventory using 11-point scale measures perceived pain interference with the performance of 7 areas of daily functioning	Dimensions: painrelated disability	High internal consistency (Cronbach a 0.86-0.93)	Demonstrate concurrent and construct validity, with score most strongly related to pain behavior	Its utility as an outcome measure needs further studies
	Dimensions: painrelated disability		Moderate test-retest reliability (r=0.44)	Suited for population in the community dwelling	
			Interrater reliability 0.99	Has been tested for chronic pain and response to treatment in older persons	
				Short and easy to use	
BPI and-Short Form (BPI-SF)[134,326–329]	11-item tool that gathers information on pain severity and rates level of pain interference on seven key aspects of function on a 0-10 NRS	10 to 15 min (interference subscale fewer than 5min)	High internal consistency (Cronbach a 0.82-0.97)	Consistently measured 2 underlying constructs, severity and interference in cancer pain, chronic pain, and acute pain	Does not evaluate affective dimension or qualities of pain
	Dimensions: severity and interference		Test-retest reliability moderate to strong (0.58-0.95)	Discriminated among levels of condition severity and was sensitive to change in condition over time	
	Has been adapted to assess pain and discomfort specifically due to the presence of herpes zoster (ZBPI)			Has been validated in over 30 languages with good psychometric properties as an intercultural, multinational research tool	

				Suited for cancer pain, noncancer chronic pain conditions, acute postsurgical pain, and acute pain and older adults	
				Generic rather than condition-specific, simple to administer and score	
GPM[137,330,331]	24-item instrument consists	5-15 min	Reliability moderate to strong (Cronbach a 0.87-0.94)	Significant correlations between GPM and MPQ (r=0.63)	Limited evaluation data
	Of 22 items scored dichotomously assessing pain-related physical and psychologic function and 2 items scored 0-10 measuring pain severity		Good test-retest reliability (r=0.74-0.90)	Suited for ambulatory geriatric clinic and nursing homes	
	Modification of GPM (GPM-M2) has 17 items. Dimensions: intensity, interference, disengagement, pain with activity		High interrater reliability (k=0.93)	Short, easy to use	
Multidimensional Pain Inventory (MPI)[136,332–334]	61-item, evaluates the impact of and adaptation to chronic pain, comprised of 13 subscales across 3 sections	Approximately 20 min	Adequate to high internal consistency (Cronbach a 0.61-0.92)	Strong concurrent validity with other multidimensional pain and interference scales	MPI classifications may not be stable, trait-like characterizations
	Dimensions: pain intensity, interference of pain with everyday activities, perceived life control, affective distress and social support		Adequate to high testretest reliability(r=0.62-0.91)	Well-established in chronic pain	Limited psychometric study in the elderly
				Cross culturally validated	
				Identifies adaptation styles and response to treatment	
Structured Pain Interview (SPI)[106]	Two questions focus on patient's presence of pain or discomfort, one question for pain location with pain map	Not specified, but likely less than 5min	Acceptable test-retest reliability (k=0.56-0.72)	Significant correlations with 0-10 scale	Not suitable for monitoring treatment response when improvements in pain are anticipated
	Dimensions: pain prevalence and location			Highly feasible tool for examining pain prevalence in nursing homes and comparing resident with nurse perspectives	
Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)[140,335–343]	24-item, available in both 5-point Likert and 100mm Visual Analog scaling format	Not specified but likely brief	Adequate to high internal consistency (Cronbach a 0.73-0.95)	Valid and widely used for knee and hip OAspecific health status with latest version available in 65 alternate language forms	May be less sensitive to change than the generic Health Assessment Questionnaire
	Dimensions: pain, disability and joint stiffness		Adequate to high testretest reliability (r=0.64-1.00)	Used in diverse clinical and interventional environments as valid, reliable and responsive measure of outcome	
				Alternative forms of administration (telephone, mousedriven cursor, touch screen)	
				Studied extensively among cognitively intact seniors and those suffering from mild to moderate dementia with better proxy pain report	
Arthritis Impact Measurement Scale (AIMS)[141,142,344–351]	78-item measure assessing the effects of rheumatoid arthritis pain, with shorter version AIMS2-SF containing 26 items, score for subscales ranges from 0 to 10	About 20 min	Acceptable internal consistency (a coefficients for the subscales 0.72-0.96)	Construct validity supported by scores correlated with related instruments	
	Adapted for elderly as		Adequate to high	GERI-AIMS correlates	

	GERI-AIMS, generates both generic and arthritis-specific impairment scores		test-retest reliability (0.78-0.94)	well with clinical measures of arthritis severity, suitable for frail elderly	
	Dimensions: physical, affect, symptom, social interaction and role				

TABLE 13. Characteristics of Clinically-Relevant Pain Assessment Tools for Seniors With Limited Verbal Communication Due to the Presence of Dementia

Name of Measure	Description of Measure	Time to Complete (times approximate)	Internal Consistency	Interrater Reliability	Validity Considerations	Limitations
Abbey Scale[177]	Six items, 0-3 scale	Less than 1 min	0.74-0.81	ICC=0.44-0.63	Moderate positive correlations between total score and a nurse's global pain assessment	Although scores significantly decreased after pain intervention (eg, medication), the raters were not blind as to whether there was an intervention
CNPI[174]	Six items, present/not present	Not specified but likely very brief	0.54-0.64	k=0.62 to 0.82 (P=0.019 to 0.006)	Significant (moderate) correlations between CNPI scores and verbal report	Low internal consistency may imply that a construct other than pain is being measured by some of the items
Discomfort Scale (DS-DAT)[173]	Nine items, 0-3 scale	5 minutes	0.86-0.89	r=0.61-0.98	Positive correlations between self-report measures and DS-DAT scores	Validity evidence based on a gold standard of illness involving fever (not pain per se) The gold standard was illness involving fever (ie, not pain per se)
DOLOPLUS-2[179]	10 items, 0-3 scale	Less than 5 min	0.82	Not reported	Significant convergent validity of the VAS and Doloplus-2 scores	English version not sufficiently researched but validation studies in English, Spanish, Italian, German, Portuguese, and Dutch are currently underway
NOPPAIN[178]	Six pain behaviors, Multiformat—yes/ no and 0-5 scale	30 s to complete the measure, 10 min to complete the observations	Not reported	Not reported	Accurate classification of pain in a simulated patient portraying a variety of pain conditions	Validity evidence based on a gold standard of an actress portraying a patient with severe dementia in a variety of pain conditions
PACI[176]	Seven items, yes/no	2 minutes	Not reported	k=0.74-0.85; ICC=0.82-0.88	Moderate correlations with 3 self-report measures of pain among some groups	Low correlations with selfreport measures of pain among some groups Validation based on a standard other than self-report is still needed for patients with dementia
PAINAD[175]	Five items, 0-2 scale	5 minutes	0.50-0.67	r=0.82-0.97	Concurrent validity indicated by positive correlations with DS-DAT scores Scores on the DS-DAT decreased following pain intervention	Low internal consistency may imply that a construct other than pain is being measured by some of the items Concerning validity evidence, there was no indication as to whether raters were blind to the intervention
PATCOA[180]	Nine items, yes/no	Not specified but likely brief	Below 0.70	% Agreement for each item=56.5% to 100%	Content validity based on factor analysis	Psychometric properties investigated among cognitively intact seniors undergoing orthopedic surgery B not investigated among seniors with cognitive impairments
PACSLAC[165]	60-item checklist, present/absent	5 minutes	0.85	0.92	Moderate correlations with nurses' global ratings of pain Ability to discriminate among painful, calm, and distressing events	Validity evidence based on nurses' retrospective reports
PADE[183]	24 items,multiformat 4-point Likert scale, Visual Analog Scale	10 minutes	0.24-0.88	ICC=0.54-0.95	The PADE could discriminate between people with clinically significant pain and those without	Although the PADE could discriminate between people with clinically significant pain and those without, a measure of verbal agitation was also able to do so (indicating that the PADE may not be pain specific) Severity of dementia of the sample is unclear (ie, described as mild to moderate, but no detailed assessment information provided) Variable results obtained for reliability evidence
Simmons and Malabar[182]	25 items, multiformat (eg, yes/no, open-ended)	8 minutes for the first evaluation, 3 min for subsequent evaluations	Not reported	Not reported	Scores were found to decrease following pain intervention	Although scores decreased after pain interventions, it is unknown whether the raters were blind as to whether there was an intervention Cognitive status of participants unclear

CNPI indicates Checklist of Nonverbal Pain Indicators; DS-DAT, Discomfort Scale for patients with Dementia of the Alzheimer Type; ICC, Intraclass Correlation Coefficient; NOPPAIN, Noncommunicative Patient's Pain Assessment Instrument; PACI, Pain Assessment in the Communicatively Impaired; PACSLAC, Pain Assessment Checklist for Seniors with Limited Ability to Communicate; PADE, Pain Assessment for the Dementing Elderly; PAINAD, Pain Assessment in Advanced Dementia; PATCOA, The Pain Assessment Tool in Confused Older Adult.

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 22
Zitat (Originalzitat): “Generally, numeric rating scales are preferable because they have good psychometric properties, minimize linguistic demands and can be completed verbally.[114] Verbal descriptor scales also have good properties with seniors and are often preferred, while visual analog scales (and, especially, vertical visual analog scales) have been found by some researchers to lead to frequent unscorable responses among seniors.[108,115] A variation of the standard pain intensity scales is the Philadelphia Geriatric Center-Pain Intensity Scale (PGC-PIS) that may have utility assessing pain and its perception by patients, including those with dementia.[116] “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 13
Zitat (Originalzitat) “Numeric rating scales, verbal descriptor scales, pain thermometers, and faces pain scales have acceptable validity and are preferred by many older adults. If the older adult is alert and oriented, use a 0-10 Numeric Rating Scale. If unsuccessful, try a Verbal Descriptor Scale or Faces Pain Scale”
Evidence-Grad: siehe Referenzen II-a – V-a Empfehlungsstärke: nicht ausgewiesen

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Weiner, D.K., Peterson, B.L., Logue, P., Keefe, F.J. (1998b). Predictors of pain self-report in nursing home residents. Aging: Clinical and Experimental Research; 10: S. 411-420. (III-a).
Zalon, M. L. (1993). Pain in frail, elderly women after surgery. Pennsylvania Nurse; 48 (11): S. 18-19. (V-a).

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Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 12-14

Zitat (Originalzitat):

"Numeric Rating Scales (NRS)

• Six-point Numeric Rating Scale (NRS 0-5) (Morrison et al., 1998).—C

• Eleven-point Numeric Rating Scale (NRS 0-10) (Bergh et al., 2000, 2001; Closs et al.,

2004; Gagliese et al., 2005; Kaasalainen & Crook, 2004; VHA/DoD, 2002).—B
• Twenty-one point Numeric Rating Scale (NRS 0-20) (Chibnall & Tait, 2001; Herr et al., 2004b; Taylor & Herr, 2003).—B"
"Verbal Descriptor Scale (VDS) appears to be easiest and most preferred by older adults and easiest for those with cognitive impairment (Bergh et al. 2000, 2001; Closs et al. 2004; Gagliese & Katz 2003; Herr et al. 2004b; Manz et al. 2000; Taylor & Herr 2003).—B
• Four-point Verbal Rating Scale (VRS) (Closs et al. 2004).—C
• Pain Thermometer (PT) (Herr & Mobily, 1993; Taylor & Herr, 2003).—B
• Present Pain Inventory Scale (PPI) (Gagliese & Katz 2003; Gagliese et al., 2005; Kaasalainen & Crook 2004; Melzack & Katz 1992; Pautex et al. 2005).—C
• Seven-point Graphic Rating Scale (GRS) (Bergh et al. 2000, 2001).—B"
"Faces Rating Scales
• Faces Pain Scale (FPS) (Bieri et al. 1990; Closs et al. 2004; Freeman et al. 2001; Herr et al., 2004b; Kaasalainen & Crook 2004; Stuppy, 1998; Taylor & Herr 2002, 2003).—B
• Wong-Baker FACES pain rating scale (Wong & Baker, 1988; Wong & Baker 1995; Wynne et al. 2000).—C
• Faces Pain Scale is not equivalent in numbering to NRS or VAS, thus it cannot be assumed that a 6 on the FPS is equal to a 6 on NRS (Freeman et al. 2001; Gagliese & Katz 2003).—C
• When faces scales are used, the patient should be taught to select the face that most represents the way they think they are feeling, not the way they think they look (Pasero, 2005).—E"

Evidence-Grad: siehe Referenzen II-a – V-b
Empfehlungsstärke: B, C und E

Referenzen:
Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patients. Aging-Clinical & Experimental Research; 12 (5): S. 380-387. (III-a).
Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2001). Assessing pain and pain relief in geriatric patients with non-pathological fractures with different rating scales. Aging-Clinical & Experimental Research; 13 (5): S. 355-361. (III-a).
Bieri, D., Reeve, R.A., Champion, G.D., Addicoat, L., Ziegler, J.B. (1990). The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: Development, initial validation, and preliminary investigation for ratio scale properties. Pain; 41: S. 139-150.(III-b).
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92 (1-2): S. 173-186. (III-a).
Closs, S.J., Barr, B., Briggs, M., Cash, K., Seers, K. (2004). A comparison of five pain assessment scales for nursing home residents with varying degrees of cognitive impairment. Journal of Pain & Symptom Management 27 (3): S. 196-205. (III-a).
Freeman, K., Smyth, C., Dallam, L., Jackson, B. (2001). Pain measurement scales: a comparison of the Visual Analogue and Faces Rating Scales in measuring pressure ulcer pain. Journal of WOCN; 28 (6): S. 290-296. (III-a).
Gagliese, L., Weizblit, N., Ellis, W., Chan, V.W.S. (2005). The measurement of postoperative pain: A comparison of intensity scales in younger and older surgical patients. Pain; 117 (3): S. 412-420.
Gagliese, L., Katz, J. (2003). Age differences in postoperative pain are scale dependent: a comparison of measures of pain intensity and quality in younger and older surgical patients. Pain; 103 (1-2): S. 11-20. (II-a).
Herr, K. A., Spratt, K., Mobily, P. R., Richardson, G. (2004b). Pain intensity assessment in older adults. Use of experimental pain to compare psychometric properties and usability ofselected pain scales with younger adults. Clinical Journal of Pain; 20 (4): S. 207-219. (II-a).
Herr, K. A., Mobily, P.R. (1993). Comparison of selected pain assessment tools for use with the elderly. Applied Nursing Research; 6 (1): S. 39-46. (III-a).
Kaasalainen, S., Crook, J. (2004). An exploration of senior's ablity to report pain. Clinical Nursing Research; 13 (3): S. 199-215. (III-a).
Manz, B.D., Mosier, R., Nusser-Gerlach, M.A., Bergstrom, N., Agrawal, S. (2000). Pain assessment in the cognitively impaired and unimpaired elderly. Pain Management Nursing; 1

(4): S. 106-115. (III-a).
Melzack, R., Katz, J. (1992). The McGill Pain Questionnaire: Appraisal & Current Status. In Turk, D.C., Melzack, R. (ed.). Handbook of Pain Assessment: 152-168. New York: Guilford. (IV-b).
Morrison, R.S., Ahronheim, J.C., Morrison, G.R., Darling, E., Baskin, S.A., Morris, J., Choi, C., Meier, D.E. (1998). Pain and discomfort associated with common hospital procedures and experiences. Journal of Pain & Symptom Management; 15 (2): S. 91-101. (III-a).
Pasero, C. (2005). Personal communication Pautex, S., Herrmann, F., Le Lous, P., Fabjan, M., Michel, J. P., Gold, G. (2005). Feasibility and reliability of four pain self-assessment scales and correlation with an observational rating scale in hospitalized elderly demented patients. Journals of Gerontology Series A: Biological Sciences & Medical Sciences; 60A (4): S. 524-529. (III-a).
Stuppy, D.J. (1998). The Faces Pain Scale: Reliability and validity with mature adults. Applied Nursing Research; 11 (2): S. 84-89. (III-a).
Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African American older adults. Pain Management Nursing; 4 (2): S. 87-95. (III-a).
Taylor, L.J., Herr, K. (2002). Assessment. Evaluation of the Faces Pain Scale with minority older adults. Journal of Gerontological Nursing; 28 (4): S. 15-23. (III-a).
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).
Wong, D., Baker, C. (1988). Pain in children: comparison of assessment scales. Pediatric Nursing; 14: S. 9-17. (III-b).
Wong, D., Baker, C. (1995). Reference Manual for the Wong-Baker FACES pain rating scale. Tulsa, OK: Wong & Baker. (V-b).
Wynne, C.F., Ling, S. M., Remsburg, R. (2000). Comparison of pain assessment instruments in cognitively intact and cognitively impaired nursing home residents. Geriatric Nursing; 21 (1): S. 20-23. . (III-a).

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 14

Zitat (Originalzitat) S. 14: „Consider racial/cultural sensitivity of tools for use with older adults of diverse racial/ethnic background. Limited studies are available regarding validity and reliability of pain assessment tools for use with older adults of different racial/ethnic backgrounds. Studies conducted with African American older adults support appropriateness of faces rating scales, numeric rating scales and verbal descriptor scales. Faces pain scales appeared to be the most preferred by African American older adults (Stuppy, 1998; Taylor & Herr, 2002, 2003)"

Evidence-Grad: siehe Referenzen III-a
Empfehlungsstärke: C

Referenzen:
Stuppy, D.J. (1998). The Faces Pain Scale: Reliability and validity with mature adults. Applied Nursing Research; 11 (2): S. 84-89. (III-a).
Taylor, L., Herr, K. (2002). Assessment. Evaluation of the Faces Pain Scale with minority older adults. Journal of Gerontological Nursing; 28 (4): S. 15-23. (III-a).
Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African American older adults. Pain Management Nursing; 4 (2): S. 87-95. (III-a).

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Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 19

Zitat (Originalzitat):
"Elicit pain statements from cognitively impaired patients, and attempt to use a selected assessment tool. Older adults with mild to moderate cognitive impairment are often able to rate pain using self-report instruments and individual patient ability to do so should be assessed. It may be necessary to try several tools to evaluate which one is most easily used by the cognitively impaired individual. Also many severely impaired persons can respond to simple questioning about presence of pain and may be able to use a simple rating scale. Scales that are the simplest and most usable for cognitively impaired older adults include verbal descriptor scales, pain thermometers, and faces pain scales (Briggs & Closs 1999; Buffum et al. 2001; Chibnall & Tait 2001; Closs et al. 2004; Feldt et al. 1998a; Ferrell, 1995; Herr & Mobily 1993; Herr et al. 2004b; Kaasalainen & Crook, 2003; Krulewitch et al. 2000; Manz et al. 2000; McCaffery & Pasero 1999; Porter et al., 1996; Scherder et al. 2003a; Taylor et al. 2005; Taylor & Herr 2003; Weiner et al. 1998b; Wynne et al. 2000).—C"

Evidence-Grad: siehe Referenzen II-a – V-b
Empfehlungsstärke C

Referenzen:
Briggs, M., Closs, J.S. (1999). A descriptive study of the use of visual analogue scales and verbal rating scales for the assessment of postoperative pain in orthopedic patients. Journal of Pain & Symptom Management; 18 (6): S. 438-446. (III-a).
Buffum, M.D., Miaskowski, C., Sands, L., Brod, M. (2001). A pilot study of the relationship between discomfort and agitation in patients with dementia. Geriatric Nursing; 22 (2): S. 80-85. (III-a).
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92 (1-2): S. 173-186. (III-a).
Closs, S.J., Barr, B., Briggs, M., Cash, K., Seers, K. (2004). A comparison of five pain assessment scales for nursing home residents with varying degrees of cognitive impairment. Journal of Pain & Symptom Management; 27 (3): S. 196-205. (III-a).
Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a).
Ferrell, B.A. (1995). Pain evaluation and management in the nursing home. Annals of Internal Medicine; 123 (9): S. 681-687. (V-a).
Herr, K.A., Mobily, P.R. (1993). Comparison of selected pain assessment tools for use with the elderly. Applied Nursing Research; 6 (1): S. 39-46. (III-a).
Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004b). Pain intensity assessment in older adults. Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20 (4): S. 207-219. (II-a).
Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research: 35 (4): S. 59-71. (III-a).
Krulewitch,H., London, M.R., Skakel, V.J., Lundstedt, G.J., Thomason, H., Brummel-Smith, K. (2000). Assessment of pain in cognitively impaired older adults: a comparison of pain assessment tools and their use by nonprofessional caregivers. Journal of the American Geriatrics Society; 48 (12). S. 1607-1611. (III-a).
Manz, B.D., Mosier, R., Nusser-Gerlach, M. A., Bergstrom, N., Agrawal, S. (2000). Pain assessment in the cognitively impaired and unimpaired elderly. Pain Management Nursing; 1 (4): S. 106-115. (III-a).
McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual (2nd ed.). St. Louis, MO: Mosby. (Vb).
Porter, F.L., Malhotra, K.M., Wolf, C.M., Morris, J.C., Miller, J. P., Smith, M.C. (1996).

Dementia and response to pain in the elderly. Pain; 68: S. 413-421. (III-a).
Scherder, E.J., Sergeant, J.A., Swaab, D.F. (2003a). Pain processing in dementia and its relation to neuropathology. Lancet Neurology; 2 (11): S. 677-686. (IV-a).
Taylor, L.J., Harris, J., Epps, C.D., Herr, K. (2005). Psychometric evaluation of selected pain intensity scales for use with cognitively impaired and cognitively intact older adults. Rehabilitation Nursing; 30 (2): S. 55-61. (III-a).
Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African American older adults. Pain Management Nursing; 4 (2): S. 87-95. (III-a).
Weiner, D.K., Peterson, B.L., Logue, P., Keefe, F.J. (1998b). Predictors of pain self-report in nursing home residents. Aging: Clinical and Experimental Research; 10: S. 411-420. (III-a).
Wynne, C.F., Ling, S.M., Remsburg, R. (2000). Comparison of pain assessment instruments in cognitively intact and cognitively impaired nursing home residents. Geriatric Nursing; 21 (1): S. 20-23. (III-a).

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 20-21

Zitat (Originalzitat):

“Use a pain assessment tool to assess presence of pain based on behavioral pain indicators when severely cognitively impaired older adults are unable to self-report. Several behavioral scales have been developed for assessing pain in the nonverbal older adults with severe dementia (Herr et al. 2006; Herr et al. 2004a); however only one has been tested for use in the acute care setting.—D”

- “The Checklist of Nonverbal Pain Indicators (CNPI) (Feldt 2000). CNPI is an observational tool developed for use with nonverbal older adults and includes six pain behavioral items commonly observed in older adults with acute pain. Preliminary tool testing has provided initial support for use of the tool with older adults in the acute care setting (Feldt 2000; Feldt et al. 1998a; Herr et al. 2006; Herr et al. 2004a) (See Appendix E).—C”

Evidence-Grad: siehe Referenzen III-a – IV-a

Empfehlungsstärke: C - D

Referenzen:

Feldt, K. (2000). The checklist of nonverbal pain indicators (CNPI). Pain Management Nursing; 1 (1): S. 13-21. (III-a).
Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a).
Herr, K., Bjøro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: a state of the science review. Journal of Pain and Symptom Management; 31 (2): S. 170-192. (IV-a).
Herr, K., Decker, S. A., Bjoro, K. (2004a). State of the art review of nonverbal pain assessment tools. From www.cityofhope.org/prc/elderly.asp (IV-a).

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 5
Zitat (Originalzitat): “II. PAIN RATING SCALE A. One of the 3 following Pain Rating Scales shall be used as appropriate for the individual resident: 1. Wong-Baker Scale 2. Numerical Scale 3. FLACC Scale” Scales werden abgebildet vgl. S. 12
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Horgas et al._2008 Horgas, A.L, Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T. (ed.). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 4
Zitat (Originalzitat): “Self-report is the gold standard for pain assessment (AGS, 2002 [Level VI]).”
Evidence-Grad: [Level VI] Empfehlungsstärke: nicht ausgewiesen
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 6
Zitat (Originalzitat): “The Brief Pain Inventory (BPI) was selected for use in this guideline because it is reliable and valid for use in older adults. It incorporates pain intensity ratings in the form of a Numeric Rating Scale (NRS) as well as pain presence, location, treatment and interference with physical and psychosocial functioning. In addition, it is brief enough for practical clinical use (Appendix A.1).”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: Daut, R.L., Cleeland, C.S., Flanery, R.C. (1983). Development of the Wisconsin Brief Pain Questionnaire to assess pain in cancer and other diseases. Pain; 17: S. 197-210. (R) Tan, G., Jensen, M.P., Thornby, J.I., Shanti, B.F. (2004). Validation of the Brief Pain Inventory for chronic nonmalignant pain. Journal of Pain; 5: S. 133-137. (R) White, S. (2004). Assessment of chronic neuropathic pain and the use of pain tools. British Journal of Nursing; 13: S. 372-378. (R) Zalon, M.L. (2004). Correlates of recovery among older adults after major abdominal surgery. Nursing Research; 53: S. 99-106.(R)

Mc Lennon_2005
Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 28-31

Zitat (Originalzitat): “There may not be one optimal persistent pain intensity instrument appropriate for all older adults. Instead, an individualized approach has been recommended (AGS 2002; Weiner et al., 2002. Evidence Grade = D). Therefore, this guideline includes optional pain intensity scales if the numeric scale from the BPI is not appropriate due to patient preferences or abilities. The Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNS), and the Faces Pain Scale (FPS) have been included as optional choices in order of recommendation for use in older adults. Further information about each of the tools follows in the next section.”

Evidence-Grad und/oder Empfehlungsstärke:
VDS: Evidence Grade = B
VNS: nicht ausgewiesen
FPS: nicht ausgewiesen

Referenzen:
American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. 1-20.(N)
Weiner, D.K., Herr, K., Rudy, T.E. (ed.) (2002). Persistent pain in older adults. New York: Springer. (L) VDS:
Closs, S.J., Barr, B., Briggs, M., Cash, K., Seers, K. (2004). A comparison of five pain assessment scales for nursing home residents with varying degrees of cognitive impairment. Journal of Pain and Symptom Management; 27: S. 196-205. (R)
Feldt, K. (2000a). Improving assessment and treatment of pain in cognitively impaired nursing home residents. Annals of Long-Term Care: Clinical Care and Aging; 8: S. 36-42. (L)
Herr, K. A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults: Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20: S. 207-218. (R)
Taylor, L.J., Harris, J., Epps, C.D., Herr, K. (2005). Psychometric evaluation of selected pain intensity scales for use with cognitively impaired and cognitively intact older adults. Rehabilitation Nursing; 30: S. 55-61. (R) VNS: Joint Commission on Accreditation of Healthcare Organizations. (2001). Accreditation manual for hospitals. Oakbrook Terrace, IL: Author. (N) FPS:
Chibnall, J., Tait, R. (2001). Pain assessment in cognitively-impaired and unimpaired older adults: A comparison of four scales. Pain; 92: S. 173-186. (R)
Herr, K.A., Mobily, P.R., Kohout, F.J., Wagenaar, D. (1998). Evaluation of the Faces Pain Scale for use with the elderly. Clinical Journal of Pain; 14: S. 29-38. (R)
Taylor, L.J., Harris, J., Epps, C.D., Herr, K. (2005). Psychometric evaluation of selected pain intensity scales for use with cognitively impaired and cognitively intact older adults. Rehabilitation Nursing; 30: S. 55-61. (R)
Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African American older adults. Pain Management Nursing; 4: S. 87-95. (R)
Weiner, D.K., Herr, K. (2002). Comprehensive interdisciplinary assessment and treatment planning: an integrative overview. In Weiner, D., Herr, K., Rudy, T. E. (ed.), Persistent pain in older adults: S. 18-57). New York: Springer. (L)

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Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 8,10
Zitat (Originalzitat): “Mild to moderately impaired older adults can self-report their pain intensity. The recommended tool is The Verbal Descriptor Scale (VDS) because it is the most sensitive and reliable in this group (Herr, Spratt, Mobily, & Richardson 2004; Taylor et al. 2005; Taylor & Herr 2003. Evidence Grade = C). However, in one study, although the VDS was sensitive and reliable, African Americans preferred the Faces Pain Scale (FPS) (Taylor & Herr 2003. Evidence Grade = C).”
Evidence-Grad und/oder Empfehlungsstärke: Evidence Grade = C).
Referenzen: Closs, S.J., Barr, B., Briggs, M., Cash, K., Seers, K. (2004). A comparison of five pain assessment scales for nursing home residents with varying degrees of cognitive impairment. Journal of Pain and Symptom Management; 27: S. 196-205. (R) Feldt, K. (2000a). Improving assessment and treatment of pain in cognitively impaired nursing home residents. Annals of Long-Term Care: Clinical Care and Aging; 8: S. 36-42. (L) Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults: Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20: S. 207-218. (R) Taylor, L.J., Harris, J., Epps, C.D., Herr, K. (2005). Psychometric evaluation of selected pain intensity scales for use with cognitively impaired and cognitively intact older adults. Rehabilitation Nursing, 30 55-61. (R) Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African Americanolder adults. Pain Management Nursing; 4: S. 87-95. (R)

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 10
Zitat (Originalzitat): “Verbal Numeric Rating Scale (VNS) (Appendix A.3) The VNS is commonly used in clinical settings, however, some elders may have difficulty comprehending and responding to this interactive verbal rating scale (Weiner, Peterson, Ladd, McConnell& Keefe 1999). Use of the VNS has been associated with higher levels of pain ratings than other scales (Herr et al. 2004).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults: Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20: S. 207-218. (R) Weiner, D.K., Peterson, B., Ladd, K., McConnell, E., Keefe, F. (1999). Pain in nursing home residents: An exploration of prevalence, staff perspectives, and practical aspects of measurement. Clinical Journal of Pain; 15: S. 92-101. (R)

Mc Lennon_2005
Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 10

Zitat (Originalzitat):
“Faces Pain Scale (Herr 2002) was originally developed to assess pain intensity in children and consists of cartoon drawings of facial expressions progressing from least to most pain (Bieri, Reeve, Champion, Addicoat, & Ziegler 1990). The FPS is not recommended in cognitively impaired older adults because of lower validity and reliability scores when compared with the VDS and NRS (Taylor et al. 2005). In one study it was the tool chosen as most preferred by African Americans (Taylor & Herr 2003).”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Bieri, D., Reeve, R.A., Champion, G.D., Addicoat, L., Ziegler, J.B. (1990). The Faces Pain Scale for self assessment of the severity of pain experience by children: Development, initial validation, and preliminary investigation for ratio scale properties. Pain; 41: S. 139-150. (R)
Herr, K. (2002). Chronic pain: Challenges and assessment strategies. Journal of Gerontological Nursing; 28: S. 20-27. (L)
Taylor, L.J., Harris, J., Epps, C.D., Herr, K. (2005). Psychometric evaluation of selected pain intensity scales for use with cognitively impaired and cognitively intact older adults. Rehabilitation Nursing; 30: S. 55-61. (R)
Taylor, L.J., Herr, K. (2003). Pain intensity assessment: a comparison of selected pain intensity scales for use in cognitively intact and cognitively impaired African American older adults. Pain Management Nursing; (4): S. 87-95. (R)

Mc Lennon_2005
Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 8

Zitat (Originalzitat):
“Several observational methods have been developed and tested to assess pain in noncommunicative older adults with severe dementia but have not been adequately tested for practical, clinical use. Two particularly promising measures are The Checklist for Nonverbal Pain Behaviors (CNBP) (Feldt, 2000b) and the NOPPAIN (Snow et al., 2004). The CNPB was modified from the Pain Behavior Scale developed by the University of Alabama at Birmingham (Richards, Nepomuceno, Riles, & Suer, 1982). The checklist incorporates assessment of six pain behaviors such as non-verbal vocalizations, facial grimacing, bracing, rubbing, restlessness, and vocalizations. However, it was tested in a group of hospitalized older adults with dementia and acute pain. It has not been evaluated adequately for use in persistent pain. Another observational method, the NOPPAIN (Snow et al., 2004) was developed for nursing assistants in long-term care to rate pain presence, response, and intensity during activities. However, it does not contain scoring information and research indicates that proxy assessments of pain may not be valid (Cohen-Mansfield, 2005; Weiner, Peterson, & Keefe, 1999). Although a specific tool is not recommended in this guideline, the literature supports the following as indicators of inadequately treated pain. These clues may also indicate that other processes may be occurring such as constipation, hunger, thirst, depression, and infection. Therefore, a thorough assessment for all potential causes should be undertaken and assistance sought when needed.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Cohen-Mansfield, J. (2005). Nursing staff members' assessments of pain in cognitively impaired nursing home residents. Pain management nursing; 6: S. 68-75. (R)
Feldt, K. (2000b). The checklist of nonverbal pain indicators (CNPI). Pain Management Nursing; 1: S. 13-21. (R)
Richards, J.S., Nepomuceno, C., Riles, M., Suer, Z. (1982). Assessing pain behavior: The UAB Pain Behavior Scale. Pain; 14: S. 393-398. (R)
Snow, A.L., Weber, J.B., O'Malley, C.M., Cody, M., Beck, C., Bruera, E. et al. (2004). NOPPAIN: A nursing assistant-administered pain assessment instrument for use in dementia. Dementia and Geriatric Cognitive Disorders; 921, S. 1-8. (R)
Weiner, D.K., Peterson, B., Keefe, F. (1999). Chronic pain-associated behaviors in the nursing home: resident versus caregiver perceptions. Pain; 80: S. 577-588. (R).

BPS & BGS_2007
The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS. RCP_2007 &
Royal College of Physicians, British Geriatric Society et al. (2007). The Assessment of Pain in Older People: National Guidelines. Concise guidance to good practice series No 8. London, Royal College of Physicians.)

Seite 36 APPENDIX 4 (BPS & BGS_2007)
Seite 9 ff. Appendix 3. (RCP_2007)

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

"Pain map, pain scales, verbal numerical rating scale, pain thermometer (Abbildung) Abbey pain scale. Evidence grade C "

Evidence-Grad: Evidence grade C
Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 40, 21 (2002) & 40, 11 (2007)

Version 2002,
"Pain assessment also includes physiological and behavioural indicators of pain and should be included in populations such as infants, children, the cognitively impaired and in persons with acute pain. (Grade of Recommendation = C)
In the non-verbal, cognitively impaired person:
a. Absence indicators
- flat affect;
- decreased interaction;
- decreased intake; and
- altered sleep pattern

b. Active indicators
- rocking;
- negative vocalization;
- frown or grimacing;
- noisy breathing;
- irritability; and
- agitation "

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation =C

Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 106 ff. (2002) & 21-22 (2007)
Zitat (Originalzitat): “APPENDIX E – Tools for Assessment of Pain in Adults SAMPLE 1 – Visual Analogue Scale (VAS) SAMPLE 2 – Numeric Rating Scale (NRS) SAMPLE 3 – Verbal Scale SAMPLE 4 - Facial Grimace & Behaviour Flow Charts SAMPLE 5 - Pain Assessment Tool and Key for Pain Assessment Tool SAMPLE 6 – Communication Worksheet for Pain Management Orders SAMPLE 7 – Calgary Interagency Pain Assessment Tool SAMPLE 8 – Brief Pain Inventory” “Version 2007 zeigt eine Revision in the Face pain scale auf S. 21 Version 2007 Checklist of Non-verbal Pain Indicators (CNPI)”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: Sample 1- 4: (Grade of Recommendation = C)
Referenzen: SAMPLE 4 - 6 Pain Assessment Tool and Key for Pain Assessment Tool: Brignell, A. (ed) (2000). Guideline for developing a pain management program. A resource guide for long-term care facilities, 3rd edition. SAMPLE 7 – Reference: Huber, S., Feser, L., Hughes, D. (1999). A collaborative approach to pain assessment. Canadian Nurse; 95 (8): S. 22-26. SAMPLE 8 – Copyright 1991 Charles S. Cleeland, PhD. Pain Research Group Face pain scale: Hicks, C., von Baeyer, C., Spafford, P., van Korlaar, I., Goodenough, B. (2001). The Faces Pain Scale – Revised: Toward a common metric in pediatric pain measurement. Pain; 93 (2). S. 173-183. ■ The Faces Pain Scale – Revised is available online at: Pediatric Pain Sourcebook of Protocols, Policies and Pamphlets. www.painsourcebook.ca. Version 2007 Checklist of Non-verbal Pain Indicators (CNPI): ■ Feldt, K. (2000). The checklist of non-verbal pain indicators (CNPI). Pain Management Nursing; 1 (1): S. 13-21. ■ The Checklist of Non-verbal Pain Indicators (CNPI) is available online at: John Hartford Institute for Geriatric Nursing and the Alzheimer’s Association – Assessing Pain in Persons with Dementia. http://www.hartfordign.org/publications/trythis/assessingPain.pdf

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 4, 39 (2007)

Zitat (Originalzitat):
“A standardized tool with established validity is used to assess the intensity of pain.
(Grade of Recommendation = C)
Visual Analogue Scale (VAS);
Numeric Rating Scale (NRS);
Verbal Scale;
Faces Scale;
Behavioural Scale.”

Evidence-Grad: Änderung 2007: The Grade of Recommendation has been changed to A from C, based on the research evidence that supports the use of a validated tool for the assessment of pain.
Empfehlungsstärke: C

Referenzen:
Scottish Intercollegiate Guidelines Network (SIGN) (2000). Control of pain in patients with cancer. SIGN.
Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services.
Briggs, M., Closs, J. (1999). A descriptive study of the use of visual analogue scales and verbal rating scales for the assessment of postoperative pain in orthopedic patients. Journal of Pain and Symptom Management; 18 (6): S. 438-446.
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
Cavender, K., Goff, M.D., Hollon, E.C., Guzzetta, C.E. (2004). Parents’ positioning and distracting children during venipuncture: Effects on children’s pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56.
Malviya, S., Voepel-Lewis, T., Burke, C., Merkel, S., Tait, A.R. (2006). The revised FLACC observational pain tool: Improved reliability and validity for pain assessment in children with cognitive impairment. Paediatric Anaesthesia; 16 (3): S. 258-265.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.
Jensen, M.P., Chen, C. & Brugger, A.M. (2002). Postsurgical pain outcome assessment. Pain, 99 (1-2): S. 101-109.
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
Krulewitch, H., London, M., Skakel, V., Lundstedt, G., Ghomason, H. Bummel-Smith, K. (2000). Assessment of pain in cognitively impaired older adults: A comparison of pain assessment tools and their use by nonprofessional caregivers. Journal of the American Gertiatric Society; 48 (12): S. 1607 1611.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 41 & 47 (2007)

Zitat (Originalzitat):
"The choice of scale should be based on the person's preferences, age, cognitive function and language and the same scale should be used each time pain is assessed and during the same level of activity (AHCPR 1992; American Pain Society, 1999).
Tailoring of tools is necessary for people with developmental delay, learning disabilities, cognitive impairment and/or emotional disturbance (ICSI 2001; RCN 1999; SIGN 2000)."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Scottish Intercollegiate Guidelines Network (SIGN) (2000). Control of pain in patients with cancer. SIGN.
Agency for Health Care Policy and Research (AHCPR) (1992). Acute pain management: Operative or medical procedures and trauma. Clinical practice guideline; (1): Rockville, MD: Agency for Health Care Policy and Research, Public Health Services, U.S. Department of Health and Human Services.
American Pain Society (1999). Quality improvement guidelines. In Pain: Clinical manual: S. 734-736. St. Louis: Mosby.
Institute for Clinical Systems Improvement (ICSI) (2001). Health care guideline: Assessment and management of acute pain.
Royal College of Nursing (RCN) (1999). Clinical practice guidelines - The recognition and assessment of acute pain in children. Technical report. London: Royal College of Nursing.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 10 (Teil I)

Zitat (Originalzitat):
"Meetinstrumenten voor de beoordeling van de intensiteit van pijn
(zie deel 2, paragraaf 3.3.1)
3l: Bij kwetsbare ouderen zonder of met milde cognitieve/communicatieve beperkingen:
– gebruik als routine een eenvoudige verbale of numerieke beoordelingsschaal om de intensiteit van pijn en de respons op de behandeling te meten, respectievelijk te bewaken (zie bijlage A).
[...Volgens
Gagliese et al. (2005) is een verticale presentatie van een VAS bij ouderen minder foutgevoelig;...]
– voor pijnintensiteitsschalen dienen grote, heldere letters/cijfers te worden gebruikt, eerder zwart/wit dan grijstinten. Presenteer de schalen bij een goede belichting.
3m: Bij kwetsbare ouderen met ernstige cognitieve/communicatieve beperkingen:
– aan de waarde van het gebruik van een instrument om de pijnintensiteit vast te stellen dient te worden getwijfeld; observationele pijnschalen lijken hier het meest betrouwbaar."

Deutsche Formulierung der Empfehlung:
3l) bei „gebrechlichen" älteren Menschen ohne oder mit milden kognitiven/kommunikativen Einschränkungen:
- Routinemäßig sollte eine numerische oder verbale Beurteilungsskala zur Einschätzung der Schmerzintensität, und zur Beurteilung einer Behandlung zu messen/erfassen, benutzt werden
- Für VAS wird eine vertikale Form empfohlen
- Für Schmerzintensitätsskalen sollte man große, helle Buchstaben / Ziffern benutzen, eher schwarzweiß als viele Grautöne. Die Skalen sollten bei guter Beleuchtung präsentiert werden.

3m) bei „gebrechlichen“ älteren Menschen mit ernsthaften kognitiven/kommunikativen Einschränkungen: die Wertigkeit der Benutzung eine Schmerzintensitätsskala wird angezweifelt; Beobachtungsschmerzskalen scheinen hier am verlässlichsten zu sein.
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zie Hadjistavropoulos et al. 2007. Chibnall, J.T. Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; (92): S. 173-86. Gagliese, L., Weizblit, N., Ellis, W., Chan, V.W. (2005). The measurement of postoperative pain: a comparison of intensity scales in younger and older surgical patiënts. Pain; 117 (3): S. 412-420. Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults. Clinical Journal of Pain; 20 (4): S. 207-19. Kaasalainen, S., Crook, J. (2004). An exploration of seniors ability to report pain. Clinical Nursing Research; 13 (3): S. 199-215. Stolee, P., Hillier, L.M., Esbaugh, J., Bol, N., McKellar, L., Gauthier, N. (2005). Instruments for the Assessment of Pain in Older Persons with Cognitive Impairment Journal of the American Geriatrics Society; 53 (2): S. 319-326. Watson, G. (2001). Low vision in the geriatric population: rehabilitation and management. Journal of the American Geriatrics Society; 49 (3): S. 317-330. Williamson, A., Hoggart, B. (2005). Pain: a review of three commonly used pain rating scales. J Clin Nurs; 14 (7): S. 798-804.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Seite: 10 (Teil I)
Zitat (Originalzitat): **“Pijnkaarten voor de lokalisatie van de pijn** (zie deel 2, paragraaf 3.3.2) 3n) Bij alle kwetsbare ouderen moet worden geprobeerd de pijn te lokaliseren door hen te vragen de pijnlijke plek(ken) aan te wijzen op hun eigen lichaam.”
Deutsche Formulierung der Empfehlung: Schmerzzeichnungen für die Lokalisation der Schmerzen 3n) bei „gebrechlichen“ älteren Menschen sollte man versuchen, den Schmerz zu lokalisieren, die betroffenen Personen bitten die schmerzhafte Regionen am eigenen Körper zu zeigen
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zie Hadjistavropoulos et al 2007. Weiner, D., Peterson, B., Keefe, F. (1998). Evaluating persistent pain in long term care residents: what role for pain maps? Pain; (76): S. 249-57 Wynne, C.F., Ling , S.M., Remsburg, R. (2000). Comparison of pain assessment instruments. Geriatric Nursing; (21): S. 21-23.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?
Zitat (Originalzitat): **“Meetinstrumenten voor de observatie van pijngedrag** (zie deel 2, paragraaf 3.3.3) 3 o) Bij kwetsbare ouderen met een ernstige cognitieve/communicatieve beperking is een observationele beoordeling essentieel voor het vaststellen van de aanwezigheid van pijn. De PACSLAC-D, PAINAD en DOLOPLUS-2 kunnen hierbij gebruikt worden (zie deel 3).

3 p) Ook bij kwetsbare ouderen zonder of met milde cognitieve/communicatieve beperkingen is een observationele beoordeling zinvol."

Seite: 10 (Teil I)

Deutsche Formulierung der Empfehlung: Messinstrumente zur Beobachtung von Schmerzverhalten

3n) bei „gebrechlichen" älteren Menschen mit ernsthaften kognitiven/kommunikativen Einschränkungen ist eine beobachtende Beurteilung essentiell für das Feststellen von Schmerzen. PACSLAC-D, PAINAD (= BESD) en DOLOPLUS-2 können dazu genutzt werden

3o) auch bei „gebrechlichen" älteren Menschen mit milden kognitiven/kommunikativen Einschränkungen ist eine beobachtende Beurteilung sinnvoll

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:

AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.

British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zie Hadjistavropoulos et al. 2007.

Herr, K. (2002). Chronic pain in the older patiënt: management strategies. 2.J Gerontol Nurs; 28 (2): S. 28-34.

Lefebvre-Chapiro, S. (2001). The Doloplus Group. The DOLOPLUS-2 scale- evaluating pain in the elderly. European Journal of Palliative Care; 8: S. 191-194.

Pautex, S., Herrmann, F., Michon, A., Giannakopoulos, P., Gold, G. (2007). Psychometric properties of the doloplus-2 observational pain scale and comparison to self-assessment in hospitalized elderly. Clinical Journal of Pain; 23 (9): S. 774-779.

Warden, V., Hurley, A.C., Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. Journal of the American Medical Directors Association; 4: S. 9-15.

Zwakhalen, S.M., Hamers, J.P., Berger, M.P. (2006b). The psychometric quality and clinical usefulness of three pain assessment tools for elderly people with dementia. Pain;126 (1-3): S. 210-220.

Zwakhalen, S.M., Hamers, J.P., Huijer-Abu, S.H, Berger M.P. (2006a). Pain in elderly people with severe dementia: a systematic review of behavioural pain assessment tools. BMC Geriatrics; 6 (3).

Verenso_2011

Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 11 (Teil I) & 4-45 (Teil II)

Zitat (Originalzitat):

"Meetinstrumenten voor een multidimensionale beoordeling van pijn (zie deel 2, paragraaf 3.3.4)

3s) Zorgprofessionals dienen zich vertrouwd te maken met relevante beoordelingsinstrumenten en deze routinematig te gebruiken. Gebruik van de Brief Pain Inventory, de Landelijke pijnanamnese of de PEG heeft de voorkeur (zie deel 3).

3t) Herhaal regelmatig de pijnmeting met methoden die geschikt en sensitief zijn bij de individuele patiënt."

Deutsche Formulierung der Empfehlung: Messinstrumente für die multidimensionale Beurteilung von Schmerzen

3 s) Die versorgenden Professionen sollten sich mit relevanten Beurteilungsinstrumenten vertraut machen und diese regelmäßig benutzen. Bevorzugt sollten Brief Pain Inventory, die ländliche Schmerzanamnese oder PEG angewandt werden

3t) die Schmerzmessung/Erfassung sollte regelmäßig mit Instrumenten, die für den individuellen Patienten geeignet und sensitiv sind, wiederholt werden.

3u) Die Schmerzmessungen/Erfassungen sollten dokumentiert werden (s. auch Fr. 29)

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zie Hadjistavropoulos et al. 2007
Auret, K.A., Toye, C., Goucke, R., Kristjanson, L.J., Bruce, D., Schug, S. (2008). Development and testing of a modified version of the brief pain inventory for use in residential aged care facilities. J Am Geri-atr Soc; 56 (2): S. 301-306.
Chaudakshetrin, P. (2009). Validation of the Thai Version of Brief Pain Inventory (BPI-T) in cancer patiënts. J Med Assoc Tha; 92 (1): S. 34-40.
Dicle, A., Karayurt, O., Dirimese, E. (2009). Validation of the Turkish version of the Brief Pain Inventory in surgery patiënts. Pain Manag Nurs; 10 (2): S. 107- 113.e2.
Gjeilo, K.H., Stenseth, R., Wahba, A., Lydersen, S., Klepstad, P. (2007). Validation of the brief pain inventory in patiënts six months after cardiac surgery. J Pain Symptom Manage. 34 (6): S. 648-656.
Kalyadina, S.A., Ionova, T.I., Ivanova, M.O. (2008). Uspenskaya OS, Kishtovich AV, Mendoza TR, Guo H, Novik A, Cleeland CS, Wang XS. Russian Brief Pain Inventory: validation and application in cancer pain. J Pain Symptom Manage; 35 (1): S. 95-102.
Keller, S., Bann ,C,M., Dodd, S.L., Schein, J., Mendoza, T.R., Cleeland ,C. (2004). Validity of the brief pain inventory for use in documenting the outcomes of patiënts with noncancer pain. Clinical Journal of Pain; 20 (5): S. 309-318.
Krebs, E.E., Lorenz, K.A., Bair, M.J., Damush, T.M., Wu, J., Sutherland, J.M., Asch, S.M., Kroenke, K. (2009). Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med; 24 (6): S. 733-738.
Oldenmenger, W.H., Stronks, D.L., Terwiel, C.T.M., Verhage, S., Gootjes, J.R.G., Klomp, M., De Wit, R. (2005). Naar een landelijke, verpleegkundige uniforme pijnanamnese. Nederlands tijdschrift voor Pijn en Pijnbestrijding; 25 (25): S. 6-12.
Poundja, J., Fikretoglu, D., Guay, S., Brunet, A. (2007). Validation of the French version of the brief pain inventory in Canadian veterans suffering from traumatic stress. J Pain Symptom Manage; 33 (6): S. 720-726.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 22 Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 29 (Teil II)

Zitat (Originalzitat):
“Naast het vragen naar de aanwezigheid van pijn kan het gebruik van een pijnmeetinstrument helpen om (de mate van) pijn vast te stellen en het effect van de pijnbehandeling te volgen. In Bijlage A bevinden sich:
Bijlage A – Pijnbeoordelingsschalen en vragenlijsten 2
A.1 BPI voor multidimensionele beoordeling pijn (zie deel 2, paragraaf 3.3.4)
A.2 PEG voor multidimensionele beoordeling pijn (zie deel 2, paragraaf 3.3.4)
A.3 Landelijke pijnanamnese voor multidimensionele beoordeling pijn (zie deel 2, paragraaf 3.3.4)
A.4 Nummerieke en verbale beoordelingsschaal voor beoordeling intensiteit pijn (zie deel 2, paragraaf 3.3.1)
A.5 PACSLAC-D meetinstrument observatie pijngedrag (zie deel 2, paragraaf 3.3.3)
A.6 PAINAD meetinstrument observatie pijngedrag (zie deel 2, paragraaf 3.3.3)
A.7 DOLOPLUS-2 meetinstrument observatie pijngedrag (zie deel 2, paragraaf 3.3.3)”

Deutsche Formulierung der Empfehlung:
s. Auch Frage 21: Neben der Frage nach Anwesenheit von Schmerzen könnte der Einsatz eines Schmerzmessinstrumentes helfen, um die Ernsthaftigkeit der Schmerzen und den Effekt der Schmerzbehandlung zu beurteilen. In der Anlage werden Beispiele von Instrumenten aufgelistet:
A Anlage A Schmerzbeurteilungsskalen und Fragebögen 2
A.1 BPI für multidimensionale Beurteilung von Schmerz (vgl Teil 2, 3.3.4)
A.2 PEG für multidimensionale Beurteilung von Schmerz (vgl. Teil 2, 3.3.4)
A.3 „Landelijke Schmerzanamanese“ (Anm ML ein Instrumente in Nl entwickelt) Ländliche Schmerzanamnese für multidimensionale Beurteilung von Schmerz (vgl. Teil 2, 3.3.4)
A.4 Numerische und verbale Beurteilungsskala für die Beurteilung von Schmerz (vgl. Teil 2, 3.3.1)
A.5 PACSLAC-D Messinstrument Beobachtung Schmerzverhalten (vgl. Teil 2, 3.3.3)
A.6 PAINAD Messinstrument Beobachtung Schmerzverhalten (vgl. Teil 2, 3.3.3)
A.7 DOLOPLUS-2 Messinstrument Beobachtung Schmerzverhalten (vgl. Teil 2, 3.3.3)

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, Hadjistavropoulos et al 2007.
Baier, R.R., Gifford, D.R., Patry, G., Banks, S.M., Rochon, T,, De Silva, D., Teno, J.M. (2004). Ameliorating pain in nursing homes: collaborative quality improvement project. JAGS; 52: S. 1988-1995.
Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patiënts. Aging Clin Exp Res; 12: S. 380-387.
Kamel, H.K., Phlavan, M., Malekgoudarzi, B., Gogal, P., Morley, J.E. (2001). Utilizing pain assessment scales increases the frequency of diagnosing pain among elderly nursing home residents. J Pain Symptom Management; 21: S. 450-455.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 22: Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 37 (Teil II)

Zitat (Originalzitat):
„Ouderen lijken de pijnthermometer makkelijker te vinden, maar de validiteit hiervan als maat voor pijnintensiteit (vooral bij degenen met cognitieve beperkingen) staat nog niet onomstotelijk vast“

Deutsche Formulierung der Empfehlung: Ältere Menschen scheinen das Schmerzthermometer einfacher zu finden, aber die Validität dessen als Maß für Schmerzintensität (vor allem bei älteren Menschen mit kognitive Eischränkungen) ist noch nicht abschließend geklärt.

Evidenz-Grad und / oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Stolee, P., Hillier, L.M. et al. (2005). "Instruments for the assessment of pain in older persons with cognitive impairment." J Am Geriatr Soc; 53 (2): S. 319-326.
Benesh, L. R., E. Szigeti, et al. (1997). "Tools for assessing chronic pain in rural elderly women." Home Healthc Nurse 15; (3): S. 207-211.

Verenso_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 22: Welche Schmerzerfassungsinstrumente sind geeignet?

Seite: 42 (Teil II)

Zitat (Originalzitat): “In Rotterdam (Erasmus Universiteit) is de Rotterdam Elderly Pain Observation Scale (REPOS) ontwikkeld De psychometrische eigenschappen ervan zijn (nog) niet in de internationale literatuur gepubliceerd. (Van Herk, 2008)“ **„Om die reden wordt dit instrument niet nader besproken“**
Deutsche Formulierung der Empfehlung: In Rotterdam (Erasmus Universität) wurde die Rotterdam Elderly Pain Observation Scale (REPOS) entwickelt. Die psychometrischen Eigenschaften sind (noch) nicht in der internationalen Literatur publiziert. Deswegen wird das Instrument hier nich näher besprochen (Van Herk, 2008)
Evidenz-Grad und / oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Van Herk, R.A. (2008). Closer look at pain in nursing home residents. PhD thesis.
Bemerkungen: aktuelle interantionale Publikationen: Boerlage, A.A., Valkenburg, A.J., Scherder, E.J., Steenhof, G., Effing, P., Tibboel, D., van Dijk, M. (2013). Prevalence of pain in institutionalized adults with intellectual disabilities: A cross-sectional approach. Res Dev Disabil; 34 (8): S. 2399-406. Boerlage, A.A., Masman, A.D., Hagoort, J., Tibboel, D., Baar, F.P., van Dijk, M. (2013). Is pain assessment feasible as a performance indicator for Dutch nursing homes? A cross-sectional approach. Pain Manag Nurs; 14 (1): S. 36-40. Van Herk, R., van Dijk, M., Tibboel, D., Baar, F.P.M., Wit De, R. (2009). The Rotterdam Elderly Pain Observation Scale (REPOS): A New Behavioral Pain Scale for Non-Communicative Adults and Cognitively Impaired Elderly Persons. Journal of Pain Management; 1 (4): S. 367-378.

Frage 23 Welche Präferenzen haben Bewohner hinsichtlich der Behandlung oder Nicht-Behandlung von Schmerzen?

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007) A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 23 Welche Präferenzen haben Bewohner hinsichtlich der Behandlung oder Nicht-Behandlung von Schmerzen?
Seite: 8
Zitat (Originalzitat): “There are age-related increases in stoicism and reticence in reporting pain. Older people demonstrate greater self-doubt than younger people and are more reluctant to label a sensation as painful [28]. Many older people living in long-term residential care may have become resigned to pain, are ambivalent about benefits of any actions for relieving their pain and may be reluctant to express pain [13]. Residents fear being perceived as ‘complaining’, they commonly do not want to worry families or bother nursing staff who are often perceived to be ‘too busy’ [13]. “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [13.] Yates, P., Dewar, A., Fentiman, B. (1995). Pain: the views of elderly people living in long-term residential care settings. Journal of Advanced Nursing; 21: S. 667-674. [28.] Yong, H-H., Gibson, S.J., de Horne, D.J., Helme, R.D. (2001). Development of a pain attitudes Questionnaire to assess stoicism and cautiousness for possible age differences. Journal of Gerontology; 56B: S. P279-P284.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 23 Welche Präferenzen haben Bewohner hinsichtlich der Behandlung oder Nicht-Behandlung von Schmerzen?
Seite: 6
Zitat (Originalzitat): “The management of pain may be further compounded by patients seeking treatment from multiple providers and concurrent (and potentially under-reported) use of over the counter drugs and complementary medicinal agents (‘‘nutraceuticals’’, herbal preparations, dietary supplements, homeopathics, etc).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Mc Lennon_2005 Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).
Frage 23 Welche Präferenzen haben Bewohner hinsichtlich der Behandlung oder Nicht-Behandlung von Schmerzen?
Seite: 10 & 28-31 (Anlage)
Zitat (Originalzitat): “However, the NRS has been identified as the most preferred by participants when compared with the other scales such as the VDS, VNS, and FPS (Herr et al. 2004; Rodriguez, McMillan, & Yarandi 2004).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Herr, K.A., Spratt, K., Mobily, P.R., Richardson, G. (2004). Pain intensity assessment in older adults: Use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. Clinical Journal of Pain; 20: S. 207-218. (R)
Rodriguez, C.S., McMillan, S., Yarandi, H. (2004). Pain measurement in older adults with head and neck cancer and communication impairments. Cancer Nursing; 27: S. 425-433. (R)

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 23 Welche Präferenzen haben Bewohner hinsichtlich der Behandlung oder Nicht-Behandlung von Schmerzen?

Seite: 11 (2007)

Zitat (Originalzitat):

- "The following parameters are part of a comprehensive pain assessment: …."
- "person's preferences and expectations/ beliefs/myths about pain management methods; and person's preferences and response to receiving information related to his/her condition and pain."

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation =C

Referenzen: nicht ausgewiesen

Frage 24 Wer sollte das Schmerzassessment durchführen?

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 11 (2012)
Zitat (Originalzitat): “The practitioner should take a medical pain related history and perform a detailed physical examination.” (…)” “Information’s from the patient`s family or the interdisciplinary team that may suggest other diagnoses and conditions.” “(Vgl. S. 1: : The term practitioner refers to both physicians and non-physician practitioners who are licensed to perform comparable functions and tasks, such as advanced practice nurses and physician assistants, consistent with state regulations and facility policy.)”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 3, 5
Zitat (Originalzitat): “Staff Observation Staff should formally observe and document both the known kinds of pain-related behaviours seen in people who are not cognitively impaired, as well as other behavioural and clinical changes that could indicate pain in people suffering from severe dementia.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: [13.] American Geriatrics Society panel guidelines on persistent pain in older persons (2002). J Am Geriatr Soc; 50: S. S205-S224.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 4
Zitat (Originalzitat): “Informant Report This involves obtaining and documenting a report from people familiar with the resident including family members, carers, nurses, personal care assistants or other informant, surrogate or proxy who knows the resident well.[16] However, this approach is not well developed and some caution is needed as, while professional carers tend to underestimate a patient’s pain, family members tend to overestimate[14] and proxy ratings have poor agreement with self-reporting”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: [16] Krulewitch, H., London, M.R., Skatel, V.J., Lundstedt, G.J., Thomason, J., Brummel-Smith, K. (2000). Assessment of pain in cognitively impaired older adults: a comparison of assessment tools and their use by non professional care givers. J Am Geriatr Soc; 48: S. 1607-1611. [14] Herr, K.A., Garand, L. (2001). Assessment and measurement of pain in older adults. In Ferrell, B. (ed.). Pain management in the elderly. Clinics in geriatric medicine. WB Saunders Company.

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 8
Zitat (Originalzitat): “Assessment Procedures Multidisciplinary collaboration between nurses, doctors, physiotherapists, other therapists and care staff is the best way to gather important information about a resident’s pain.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 4
Zitat (Originalzitat): “Health care professionals should familiarise themselves with the range of behaviours which may indicate the presence of pain. These behaviours differ between individuals and between pains: none are specific indicators of pain. Regular care-givers may be more sensitive to the meaning of behaviours, but it is important not to dismiss the possibility of pain without further attempts to assess it.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 110
Zitat (Originalzitat): “A movement-based protocol for pain assessment suggested by Husebo et al.73 includes guiding the older adult to (1) open both hands one at a time, (2) stretch both arms toward the head one arm at a time, (3) stretch both hips and knees one leg at a time, (4) turnin bed to both sides, and (5) sit at the bedside. It is important to note, however, that this protocol should be conducted by a qualified health professional such as a physiotherapist, or under a physiotherapist’s supervision, given the frailty that is frequent in this population.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Husebo, B.S., Strand, L.I., Moe-Nilssen, R., Husebo, S.B., Snow, A.L., Ljunggren, A.E. (2007). Mobilization–Observation–Behavior–Intensity–Dementia Pain Scale (MOBID): development and validation of a nurseadministered pain assessment tool for use in dementia. J Pain Symptom Manage; 34: S. 67–80.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: S4
Zitat (Originalzitat): „Interdisciplinary evaluation and collaboration are often necessary to address the full range of the older person’s health-related circumstances “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: S6
Zitat (Originalzitat): “Surrogates such as family members and caregivers may also provide useful information, especially among seniors who have difficulty communicating. Surrogates are often able to report on overt or subtle changes in behavior that might be indicative of pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: S25
“Observational tools: (…) These scales can be further categorized in terms of whether they require information from a collaborative informant (eg, about changes in sleeping and eating patterns) or whether an observer, who is unfamiliar with the patient, can administer them.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 28 (2007)
Zitat (Originalzitat): “It is anticipated that individual nurses will perform only those aspects of pain assessment and management for which they have received appropriate education and experience, and which are within the scope of their practice.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 37 (2007)
Zitat (Originalzitat): “Effective pain assessment and management is multidimensional in scope and requires coordinated interdisciplinary intervention.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 46 (2007)
Zitat (Originalzitat): “Documentation of the assessment/reassessment of pain with a standardized tool on a regular basis is required. This may be accomplished by the nurse or by teaching the person and family/care providers to self-report/report and document the findings. Assess the patient and family’s understanding and accurate use of the selected tool and provide education on the use of the tool (RCN 1999).”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: nicht ausgewiesen

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 10 (Teil I)
Zitat (Originalzitat): “3 q) Professionele verzorgenden of mantelzorgers van kwetsbare ouderen met een ernstige cognitieve/communicatieve beperking dienen betrokken te worden bij de beoordeling van de pijn.”
Deutsche Formulierung der Empfehlung: 3 q) man sollte die versorgenden Personen und „Betreuenden“ von „gebrechlichen“ älteren Menschen mit ernsthaften kognitiven/kommunikativen Einschränkungen bei der Beurteilung von Schmerz mit einbeziehen
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 17 (Teil I) & 97 (Teil II)
Zitat (Originalzitat): **Aanbevelingen over de organisatie van zorg bij pijnmanagement** (zie deel 2, hoofdstuk 6, paragraaf 6.6) “6 b) Iedere instelling dient te beschikken over een multidisciplinair samengesteld pijnteam, dat de (vanuit de directie gedelegeerde) verantwoordelijkheid heeft om te zorgen dat pijn bij kwetsbare ouderen in de instelling op een adequate manier wordt gesignaleerd, gediagnosticeerd en behandeld. Dit pijnteam zorgt daartoe voor de inrichting van de werkprocessen, kennisoverdracht en is beschikbaar voor consultatie. Ook kan ervoor gekozen worden dat het multidisciplinaire pijnteam daarnaast individuele patiënten behandelt."
Deutsche Formulierung der Empfehlung: 6 b) Empfehlungen für das Organisieren der Versorgung bezüglich des Schmerzmanagements. Jede Institution sollte über ein multidisziplinär zusammengestelltes Schmerzteam verfügen. (…) das die Verantwortung trägt für eine adäquate Art der Schmerzbeschreibung, der

Schmerzdiagnostik und der Schmerzbehandlung. Das Schmerzteam sorgt für die Einrichtung der Arbeitsprozesse, Kenntnisweitergabe und steht für die Konsultation zur Verfügung (…)
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S., Beland, F. (2009).Transforming long-term care pain management in North America: the polisclinical interface. Pain Med.; 10 (3): S. 506-20.

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 17 (Teil I) & 97 (Teil II)
Zitat (Originalzitat): **Aanbevelingen over de organisatie van zorg bij pijnmanagement** “(zie deel 2, De volgende disciplines dienen – afhankelijk van de problematiek van de oudere patiënt – multidisciplinair in het pijnteam vertegenwoordigd te zijn: verzorgende/verplegende, de hoofdbehandelaar, psycholoog, (geriatrie-) fysiotherapeut, apotheker, diëtist en ergotherapeut. In de tweede lijn kunnen daarnaast de volgende disciplines betrokken zijn: klinisch geriater, internist (ouderengeneeskunde), neuroloog, (ouderen)psychiater en anesthesioloog.”
Deutsche Formulierung der Empfehlung: Im Schmerzteam sollten Pflegende, Hauptbehandelnde; Psychologen; Physiotherapeuten; Apotheker, Ernährungsberater und Ergotherapeuten vertreten sein. Des Weiteren können auch der klinische Geriater, Internist, Neurologe, Psychiater und Anästhesiologe einbezogen werden.
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Verenso_2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 24 Wer sollte das Schmerzassessment durchführen?
Seite: 27 (Teil II)
Zitat (Originalzitat): “Volledige beoordeling van pijn gebeurt idealiter multidimensioneel en multidisciplinair. Alle zorgverleners en de mantelzorgers van de patiënt zijn daarbij van belang (Hadjistavropoulos et al. 2007).”
Deutsche Formulierung der Empfehlung: Eine komplette Schmerzbeurteilung wird idealerweise multidimensional und multidisziplinär durchgeführt. Alle Versorgenden und „Mantelzorgers“ des Patienten sind dabei wichtig.
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Lynn, Beattie B., Chibnall, J.T., Craig, K.D., Ferrell, B., Ferrell, B., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S.J., Harrison, E.L., Katz, B., Keefe, F.J., Lieber, S.J., Lussier, D., Schmader, K.E., Tait, R.C., Weiner, D.K., Williams, J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons Clinical Journal of Pain; 23 (Supplement): S. S1-S43.

Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?
Seite: 10 (2012)
Zitat (Originalzitat): **STEP 3** “Provide appropriate interim treatment for pain. If a patient is experiencing pain that is not being treated or is not adequately relieved by existing therapies, the practitioner should adjust or prescribe a pain relief regimen to maximize the patient' s comfort and minimize side effects while actively assessing the patient for underlying causes of the pain. Patients with acute injury should receive pain medication while awaiting diagnostic testing or transfer to the emergency department”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?
Seite: 14-15 (2012)
Zitat (Originalzitat): “Adopt a patient-centered interdisciplinary care plan. After reviewing the characteristics and causes of the patient' s pain, the practitioner should help the interdisciplinary team to develop a treatment plan tailored to the patient' s needs and preferences. (…) Ideally; the team should create a care plan that addresses a patient's "total pain," including - Physical conditions (…) - Psychological issues, (…) that may impact the intensity of the pain; - Social or interpersonal problems, (…) that may impact the effectiveness of the pain plan; - Spiritual issues, (…) that may inhibit optimal pain management or directly cause psychic or existential pain; and - Review of restrictions previously placed on the patient that may no longer be applicable from a palliative care perspective (e.g., alcohol, diet). At a minimum, the care plan should incorporate the following elements: - The pain scale that should be used consistently to measure the patient’s pain and the recommended frequency of reassessments using this scale (e.g., 1 hour after administration of the pain medication). The scale being used should be clearly identified to all staff members caring for the patient; - The extent to which underlying causes can be addressed and the likely impact on pain symptoms of doing so; - The patient's goals for pain management, including the desired level of pain reduction or acceptable level of pain to be achieved by implementing the plan; - Measurable patient-centered functional outcomes. …; - Frequency with which the patient' s progress and responses to attempted pain management need to be monitored and who will do the monitoring; - Comfort measures to be implemented by nurses and other staff members to enhance the effectiveness of the plan; - Potential adverse effects of treatments and the recommended frequency of monitoring for

those effects along with interventions to lessen or eliminate any negative outcomes that could decrease plan effectiveness; and - For cognitively impaired patients, documentation that the care plan was discussed with and agreed upon by the health care proxy."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?
Seite: 6
Zitat (Originalzitat): "Information collected from the Pain Assessment is to be used to formulate and implement a resident specific Pain Treatment Plan within the facility, or the resident shall be referred for treatment or consultation."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?
Seite: 21
Zitat (Originalzitat): "Pain Treatment Standard: A Pain Treatment is documented and effectiveness of treatment is recorded using the Pain Rating Scale. Treatment plans are adjusted in response to resident outcomes."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Horgas et al._2008 Horgas A.L., Yoon S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T. editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?
Seite: 5
Zitat (Originalzitat): „Patient Benefits **Patient** - Absence of pain or pain that is a level that patient judges as acceptable - Maintenance of the highest level of self-care, functional ability, and activity level possible - Absence of iatrogenic complications, such as falls, gastrointestinal upset/bleed, or altered cognitive status **Nurse** - Demostration of ongoing and comprehensive pain assessment - Documentation of prompt and effective pain management interventions - Documentation of systematic evaluation of treatment effectiveness - Demostration of knowledge of pain management in older patients, including assessment strategies, pain medications, nonpharmalogical interventions,patient and family education

Institution

- Evidence of documentation of pain assessment, intervention, and evaluation of treatment effectiveness
- Evidence of referall to specialists for specific therapies (e.g., psychiatry, psychology, biofeddback, physical therapy or pain treatment centers)
- Evidence of pain management resources for stuff (e.g., care planning, and pain management references, paim management consultants)"

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Mc Lennon_2005

Mc Lennon, M. (2005). Persistent Pain Management in Older Adults Evidence-based Guideline. The University of Iowa College of Nursing).

Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?

Seite: 26

Zitat (Originalzitat):

"In general, a pain intensity or pain impact score greater than 3 indicates a need for revision of the treatment plan (Cleeland & Syrjala, 1992; McCaffery & Pasero, 1999; Syrjala 1993. Evidence Grade = D)."

Evidence-Grad und/oder Empfehlungsstärke: Evidence Grade = D

Referenzen:

Cleeland, C.S., Syrjala, K.L. (1992). How to assess cancer pain. In D.C. Turk, R. Melzack (ed.). Handbook of pain assessment: S. 362-387, New York: Guilford Press. (L)

McCaffery, M., Pasero, C. (1999a). Assessment: underlying complexities, misconceptions, and practice tools. In M. McCaffery & C. Pasero (Ed.), Pain: clinical manual (2 th ed.):S. 35-102. Philadelphia: Mosby. (L)

McCaffery, M., Pasero, C. (1999b). Practical nondrug approaches to pain. In McCaffery, M., Pasero, C. (Ed.). Pain: clinical manual (2nd ed.): S. 399-427. Philadelphia: Mosby. (L)

Syrjala, K.L. (1993). Integrating medical and psychological treatments for cancer pain. In Chapman, C.R.; Foley, K.M. (ed). Current and Emerging Issues in Cancer Pain: Research and Practice: S. 393-409. New York: Raven Press. (L).

RNAO_2002_2007

Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 25 Welche Konsequenz sollte das Ergebnis des Schmerzassessments für die Bewohner haben?

Seite: 15 (2002) & 7 (2007)

Zitat (Originalzitat):

"Establish a plan for management in collaboration with interdisciplinary team members that is consistent with individual and family goals for pain relief, taking into consideration the following factors:

- assessment findings;
- baseline characteristics of pain;
- physical, psychological, and sociocultural factors shaping the experience of pain;
- etiology;
- most effective pharmacological and non-pharmacological strategies;
- management interventions; and
- current and future primary treatment plans."

Evidence-Grad: nicht ausgewiesen

Empfehlungsstärke: C

Referenzen:

Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13

(6b): S. 74-90.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: S210
Zitat (Originalzitat): “The risks and benefits of various assessment and treatment options should be discussed with patients and family, with consideration for patient and family preferences in the design of any assessment or treatment strategy. (IIIC) „
Evidence-Grad: III Empfehlungsstärke: C
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.205-224.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: S220
Zitat (Originalzitat): “Primary care physicians need to work with pain specialists and palliative care providers to enhance communication, improve appropriate referrals, and share the responsibility for the care of elderly patients with persistent pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 6 (2012)
Zitat (Originalzitat): “Communication. Staff members should communicate information about a patient's pain in a timely fashion to those who will act upon the information. Facilities should consider the following actions: - Adopt a patient-centered approach that promotes the patient's involvement, to the extent feasible, in the pain management care plan, including setting specific pain goals, the choice of an assessment scale, and the choice of nonpharmacologic and pharmacologic treatment modalities. For example, this should include the use of an "I" care plan in which each goal is written in the first person (e.g., "My acceptable level of pain is ... ") - Encourage all members of the interdisciplinary team to use a common vocabulary to describe pain and a standard set of pain assessment tools that are understood by everyone who uses them. - Document ongoing pain assessment and the effectiveness of all treatments in every patient’s medical record. - Establish a systematic approach to care, such as making pain assessment a routine part of every care plan meeting. - Establish an inclusive approach to care that includes seeking the input of the patient, of family members, and of direct care staff who are familiar with the patient-including the

nursing assistant, who usually knows the patient best and spends the most time with the patient. - Designate a staff member who is accountable for ensuring that all patients are properly assessed or evaluated for pain and receive adequate, appropriate treatment. - Instruct Minimum Data Set (MDS) coordinators who are reviewing and recording all aspects of patient care to communicate to the practitioner if they note a patient who is in significant pain often. - Ensure that the facility's processes for assessing and evaluating patients, reporting critical information, and obtaining timely responses from practitioners function optimally. - Consider pain management as a standard quality improvement program"
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 8
Zitat (Originalzitat): "Assessment Procedures Multidisciplinary collaboration between nurses, doctors, physiotherapists, other therapists and care staff is the best way to gather important information about a resident's pain. The clinical team should explain the purpose and scope of an assessment to the resident and family member/ representative beforehand. This helps the resident to be involved in understanding and managing identified pain"
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 7
Zitat (Originalzitat): "Good practice principles for the assessment of pain can be summarised as: - A resident and his or her representative must be informed about, and actively involved in, pain assessment and management so that optimum outcomes can be achieved and procedures can be balanced with the resident's wishes and the overall aims of care. - Multidisciplinary collaboration between doctors, nurses, physiotherapists and other care staff is the key to effective pain assessment and management."
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain 23(1): S. 1-43.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 3
Zitat (Originalzitat): "For assessment data to be useful, they must be communicated across providers and care settings. Documentation procedures that facilitate monitoring and communication are recommended."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 8-9
Zitat (Originalzitat): “VIII. POLICY A. Each facility shall develop a policy to define the system for assessing and monitoring resident pain. B. The policy for each facility shall include the criteria found in subchapter 6, General Licensure Procedures and Enforcement of Licensure Rules, NJAC 8:43E 6.4(f) 1-7: “(f) The facility shall establish written policies and procedures governing the management of pain that are reviewed at least every three years and revised more frequently as needed. They shall include at least the following: 1. A written procedure for systematically conducting periodic assessment of a patient’s/resident’s pain, as specified in (b) *above. At a minimum the procedure must specify pain assessment upon admission, upon discharge, and when warranted by changes in a patient’s/resident’s condition and self reporting of pain; 2. Criteria for the assessment of pain, including, but not limited to: pain intensity or severity, pain character, pain frequency or pattern, or both; pain location, pain duration, precipitating factors, responses to treatment and the personal, cultural, spiritual, and/or ethnic beliefs that may impact an individual’s perception of pain; 3. A written procedure for the monitoring of a patient’s/resident’s pain; 4. A written procedure to insure the consistency of pain rating scales across departments within the health care facility; 5. Requirements for documentation of a patient’s/resident’s pain status on the medical record; 6. A procedure for educating patients/residents and, if applicable, their families about pain management when identified as part of their treatment 7. A written procedure for systematically coordinating and updating the pain treatment plan of a patient/resident in response to documented pain status.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 15
Zitat (Originalzitat): **“Complete a comprehensive assessment of the patient’s pain with the assistance of the patient and/or the family.”**
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 13 (2002) & 6 (2007)

Zitat (Originalzitat): “Teach individuals and families (as proxy recorders) to document pain assessment on the appropriate tools when care is provided. This will facilitate their contributions to the treatment plan and will promote continuity of effective pain management across all settings”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: Grade of Recommendation: C
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 15, 49 (2002) & 7 (2007)
Zitat (Originalzitat): “Provide individuals and families/care providers with a written copy of the treatment plan to promote their decision-making and active involvement in the management of pain. The plan will be adjusted according to the results of assessment and reassessment. Changes to the treatment plan will be documented and communicated to everyone involved in the implementation of the plan.”
Evidence-Grad:nicht ausgewiesen Empfehlungsstärke: Grade of Recommendation : A
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services. Agency for Health Care Policy and Research (AHCPR) (1992). Acute pain management: Operative or medical procedures and trauma. Clinical practice guideline; (1): Rockville, MD: Agency for Health Care Policy and Research, Public Health Services, U.S. Department of Health and Human Services. American Pain Society (1999). Quality improvement guidelines. In Pain: Clinical manual: S. 734-736. St. Louis: Mosby. Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90. van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491. Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229. Alamo, M.M., Moral, R.R., de Torres, L. (2002). Evaluation of a patient-centred approach in generalized musculoskeletal chronic pain/fibromyalgia patients in primary care. Patient Education and Counseling; 48 (1): S. 23-31.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?
Seite: 23 (2007)

Zitat (Originalzitat):
“Provide the person and their family/care providers with information about their pain and the measures used to treat it, with particular attention focused on correction of myths and strategies for the prevention and treatment of side effects.”

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation: A

Referenzen:
Scottish Intercollegiate Guidelines Network (SIGN) (2000). Control of pain in patients with cancer. SIGN.
Hill, J., Bird, H. Johnson, S. (2001). Effect of patient education on adherence to drug treatment for rheumatoid arthritis: A randomized controlled trial. Annals of Rheumatic Diseases; 60 (9): S. 869-875.
Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?

Seite: 13 (2002) & 6, 49 (2007)

Kommunikation mit Familie und im interdisziplinärem Team wird empfohlen
Zitat (Originalzitat):
“S. 13 (2002): Teach individuals and families (as proxy recorders) to document pain assessment on the appropriate tools when care is provided. This will facilitate their contributions to the treatment plan and will promote continuity of effective pain management across all settings. Grade of Recommendation =C
S. 13 (2002): Validate with persons/care providers that the findings of the pain assessment
(health care provider’s and person’s/care provider’s) reflect the individual’s experience of pain.
Grade of Recommendation =C
(…)
S. 6 (2007): Communicate to members of the interdisciplinary team pain assessment findings by describing parameters of pain obtained through the use of a structured assessment tool, the relief or lack of relief obtained from treatment
methods and related adverse effects, person’s goals for pain treatment and the effect of pain on the person. Grade of Recommendation =C [**]
S.46: The monitoring tool should be kept where the team members all have access to the information (deRond, deWit, vanDam & Muller, 2000).
S.49: On a regular ongoing basis, communicate and discuss all parameters of the pain assessment with the person, the family/care provider, colleagues, physicians and other health professionals in all settings. Initiate and coordinate referral to specialists when required.
S.49: Clear, concise and ongoing communication among all members of
the interdisciplinary team is an essential aspect of pain management (SIGN, 2000).”

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: C

Referenzen:
Scottish Intercollegiate Guidelines Network (SIGN) (2000). Control of pain in patients with cancer. SIGN.
de Rond, M.E., de Wit, R., van Dam, F.S., Muller, M. J. (2000). A pain monitoring program for nurses: Effects on communication, assessment and documentation of patients’ pain. Journal of Pain and Symptom Management, 20 (6), S. 424-439.
Alamo, M.M., Moral, R.R., de Torres, L. (2002). Evaluation of a patient-centred approach in generalized musculoskeletal chronic pain/fibromyalgia patients in primary care. Patient Education and Counseling; 48 (1): S. 23-31.

American Pain Society (APS) (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS).
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?

Seite: 28 (2007)

Zitat (Originalzitat):
“It is acknowledged that effective patient care depends on a coordinated interdisciplinary approach incorporating ongoing communication between health professionals and patients, ever mindful of the personal preferences and unique needs of each individual patient.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

[_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 26 Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für das Assessment notwendig?

Seite: 10 (Teil I) & 8, 32 (Teil II)

Zitat (Originalzitat):
“3h) Geef aan kwetsbare ouderen en hun mantelzorger/ vertegenwoordiger de patiëntenfolder over ‘Ouderen en Pijn, tips voor patiënten en hun familie en mantelzorgers’.
De folder is ontwikkeld op basis van deze richtlijn en beschikbaar via de website van Verenso (www.verenso.nl).”
“3i) Geef aan verzorgenden en verpleegkundigen de handleiding ‘Tips voor verzorgenden en verpleegkundigen over ouderen en pijn’. Deze handleiding is ontwikkeld op basis van deze richtlijn en beschikbaar via de website van Verenso (www.verenso.nl).”

Deutsche Formulierung der Empfehlung: „3 h) Es eine Patientenbroschüre sollte an die gebrechlichen Älteren, die Verantwortlichen und Versorgenden überreicht werden. (Die Broschüre wird entwickelt auf Basis der Leitlinie)“
„3 i) An die Pflegenden und Versorgenden sollte die Handreichung mit „Tipps für ältere Menschen und Schmerz für Versorgende und Pflegepersonal“ gegeben werden „

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zi Hadjistavropoulos et al 2007.
Cohen-Mansfield, J. (2002). Relatives’ Assessment of pain in cognitively impaired nursing home residents. Journal of Pain & Symptom Management; 24: S. 562-571.

Frage 27 Wie zeitstabil muss das Ergebnis des Schmerzassessments sein?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.
Frage 27 Wie zeitstabil muss das Ergebnis des Schmerzassessments sein?
Seite: S210
Zitat (Originalzitat): “Patients with persistent pain should be reassessed regularly for improvement, deterioration, or complications. (IIIA)“
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.
Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Seite: 208
Zitat (Originalzitat): “Assessment and treatment strategies need to be sensitive to culture and ethnicity, as well as the values and beliefs of individual patients and families. Information from family and other caregivers should also be included in the assessment.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Seite: 1-2
Zitat (Originalzitat): “Table 1 KNOWN BARRIERS TO ACCURATE PAIN IDENTIFICATION **Cognitive and communicative impairments** - Dementia - Dysphasia - Hearing and vision loss - Dysarthria **Social diversity** - Educational levels - Cultural, ethnical and linguistic differences Resident´s attitudes Many elderly people simply don´t expect pain relief because:[10] - Pain is considered an expected part of ageing - They fear that pain may suggest worsening disease - They are concerned about being seen as complainers - They fear distracting physicians from the treatment of the underlying disease Resident´s often belief:[2] - Chrinic pain does not change - Their careers will be more influenced by external visible signs, rather than their own pain reports - They will become addicted to medication - Reporting pain will reduce permitted interpendence **Staff workloads** - Nurses ans care stuffs believe that workloads pressure means a lack of time for adequate pain assessment[2] “ “(…) Any reports of pain from cognitively-impaired residents who are communicative should be accepted as just as valid and reliable as reports from residents with no cognitive impairment. [8,9] ”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[10] Sengstaken, E.A., King, S.A. (1993). The problem of pain and ist detection among geriatric nursing home residents. J Am Geriatr Soc; 41: S. 541-544.
[2] Weiner, D.K., Herr, K. (2002). Comprehensive interdisciplinary assessment and treatment planning: an integrated overview. In Weiner, D., Herr, K., Rudy, T. (ed.). Persistent pain in older adults, an interdisciplinary guide for treatment. Springer.
[8] Ferrell, B.A., Ferrell, B.R., Rivera, L. (1995). Pain in cognitively impaired nursing home patients. J Pain Symptom Manage; 10: S. 591-598.
[9] Parmelee, P.A., Smith, B., Katz, I.R. (1993). Pain complaints and cognitive status among elderly institution residents. J Am Geriatr Soc; 41 (5): S. 517-22.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Seite: 11
Zitat (Originalzitat): “Qualitative studies exploring health professionals attitudes towards older people with persistent pain suggest that staff tend to perceive older people in pain as a heterogeneous group, with some patients perceived as ‘exaggerating’ their pain and some ‘enduring’ their pain. Staff perceptions affected the pain-relieving interventions offered to patients[43].”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [43.] Blomqvist K. (2003). Older People in persistent pain: nursing and paramedical staff perceptions and pain management. Journal of Advanced Nursing; 41 (6): S. 575-584.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Seite: 18
Zitat (Originalzitat): “Cognitively impaired older people under report pain. However, when older people with cognitive impairment report pain, their self-reports of pain are no less valid than those of cognitively intact individuals[17].”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [17.] Parmelee, P.A., Smith, B., Katz, I.R. (1993). Pain complaints and cognitive status among elderly institution residents. Journal of the American Geriatrics Society; 41: S. 517-522.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23(1): S1-43.
Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Seite: S26

Zitat (Originalzitat):
“Behavioral observation is an appealing alternative to self -report as it is not de pendent on the verbal ability of the older person. However, observation as a means for assessment is more difficult to decode and interpret than self-report information. Observation depends on making inferences about behavior and these inferences may be biased and require validation. Moreover, the behaviors observed will vary depending on whether the observation period includes patients at rest, engaged in activity, or following some activity or examination that may have invoked or alleviated pain. In ad dition, who is present (eg, caregiver, family member) may influence the behaviors observed. Differences in the observation period between 2 raters might lead to different conclusions and observation may appear unreliable. However, it might not be the procedure but rather the observation period and different activities that might lead to variability in the presence and absence of pain behavior s (see Table 3 for an overall approach to the assessment of older patients with cognitive and communication impairments).”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?

Seite: 14

Zitat (Originalzitat):
“Allow sufficient time for the older adult to process information and to respond
Parmalee et al., 1993; Weiner et al., 1998a“

Evidence-Grad: siehe Referenzen III-a – V-a
Empfehlungsstärke: C

Referenzen:
AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a).
Bergh, I., Sjostrom, B., Oden, A., Steen, B. (2000). An application of pain rating scales in geriatric patients. Aging-Clinical & Experimental Research; 12 (5), S. 380-387. (III-a).
Ferrell, B.A. (1995). Pain evaluation and management in the nursing home. Annals of Internal Medicine; 123 (9): S. 681-687. (V-a).
Parmelee, P.A., Smith, B., Katz, I.R. (1993). Pain complaints and cognitive status among elderly institutionalized residents. Journal of the American Geriatrics Society; 41: S. 517 - 522.
Weiner, D., Peterson, B., Keefe, F. (1998a). Evaluating persistent pain in long term care residents: What role for pain maps? Pain; 76 (1-2): S. 249-257. (III-a).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?

Seite: 21

Zitat (Originalzitat):
“Be aware that older adults with dementia may not exhibit pain behaviors. These patients show fewer physiological signs and behaviors and exhibit distorted facial expressions that are difficult to interpret (Fisher-Morris & Gellatly, 1997; Porter et al., 1996).—C”

Evidence-Grad: siehe Referenzen III-a & V-a

Empfehlungsstärke: C
Referenzen: Fisher-Morris, M., Gellatly, A. (1997). The experience and expression of pain in Alzheimer patients. Age & Ageing; 26: S. 497-500. (V-a). Porter, F.L., Malhotra, K. M., Wolf, C.M., Morris, J.C., Miller, J.P., Smith, M.C. (1996). Dementia and response to pain in the elderly. Pain; 68: S. 413-421. (III-a).

Horgas et al._2008 Horgas, A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T. (ed.). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
Frage 28 Welche Faktoren beeinflussen die Interpretation des Ergebnisses des Schmerzassessments?
Seite: 3
Zitat (Originalzitat): “Older adults with cognitive impairment experience pain but are often unable to verbalize it. (Smith 2005 [Level I]) Both patients and health care providers have personal beliefs, prior experiences, insufficient knowledge, and mistaken beliefs about pain and pain management that: - Influence the pain management process - Must be acknowledged before optimal pain relief can be achieved (American Geriatric Society [AGS], 2002 [Level VI])”
Evidence-Grad: [Level VI] Empfehlungsstärke: nicht ausgewiesen
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. J Am Geriatr Soc; 50 (6 Suppl): S. S205-S224. Smith, M. (2005). Pain assessment in nonverbal older adults with advanced dementia. Perspect Psychiatr Care; 41 (3): S. 99-113.

Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Seite: 13-14 (2012)
Zitat (Originalzitat): **STEP 10:** “Summarize the characteristics and causes of the patient's pain and assess the impact of pain on function and quality of life. The practitioner and staff should collaborate on documenting a summary of the patient' s situation that includes - A description of the diagnoses and conditions contributing to the patient' s pain or the reasons that the causes of the pain could not be established; - A list of possible treatments for underlying diagnoses or conditions that are contributing to the patient' s pain; - Reasons for recommending the use or nonuse of identified treatment options, taking into account the patient' s state of health, prognosis, and advance care directives, as well as the preferences of the patient and family or health care proxy; and - Provision for access to family and friends, life review, quality life experiences, and completion of unfinished business at the end of life.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Seite: 3
Zitat (Originalzitat): “Staff Observation Staff should formally observe and document both the known kinds of pain-related behaviours seen in people who are not cognitively impaired, as well as other behavioural and clinical changes that could indicate pain in people suffering from severe dementia.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Seite: 4
Zitat (Originalzitat): “Informant Report This involves obtaining and documenting a report from people familiar with the resident including family members, carers, nurses, personal care assistants or other informant, surrogate or proxy who knows the resident well.[16] “
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: [16] Krulewitch, H., London, M.R., Skatel, V.J., Lundstedt, G.J., Thomason, J., Brummel-Smith, K. (2000). Assessment of pain in cognitively impaired older adults: a comparison of assessment tools and their use by non professional care givers. J Am Geriatr Soc; 48: S. 1607-1611.

APS_2005
Pain in Residential Aged Care Facilities – Management Strategies (2005).

Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?

Seite: 56

Zitat (Originalzitat):
“Quality Indicators for Documenting Pain
Clearly defined indicators that enable objective, transparent, valid, reliable and quantifiable evaluation of pain documentation review have also been developed [10] (Table 20).”
“Table 20
PAIN ASSESSMENT INDICATORS FOR PAIN DOCUMENTATION REVIEW

1. Location
2. Quality – description
3. Intensity
4. What makes pain worse
5. What makes pain better?
6. Prior pain treatments
7. Response to prior pain causality
8. Patient goals for pain treatment
9. Effects of pain on activities of daily living
10. Effects of pain on mood

Weissmann DE, Griffle J, Muchka S, Matson S. Building an institutional commitment to pain management in long-term-care facilities. J Pain Symptom Manage 2000; Volume 20 No 1 July.”

“The developers of these indicators considered the presence of eight of the Table 20 indicators represented an acceptable level of documentation. The 10th indicator, "effects of pain on activities of daily living", was regarded as obligatory for an acceptable outcome. Overall, the study found that the number of facilities meeting more than 51 per cent of the indicators, increased from 14 per cent at baseline to 74 per cent at completion of their systematic program of education, (…).”

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
[10.] Weissman, D.E., Griffie, J., Muchka, S., Matson, S. (2000). Building an institutional commitment to pain management in long-term care facilities. J Pain Symptom Manage; 20 (1).

Hadjistavropoulos et al_2007
Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23(1): S1-43.

Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?

Seite: 3

Zitat (Originalzitat): “Documentation concerning the older adult’s report of pain must be kept in an accessible location. For assessment data to be useful, they must be communicated across providers and care settings. Documentation procedures that facilitate monitoring and communication are recommended.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Seite: 7
Zitat (Originalzitat): “Pain Assessment findings shall be documented in the resident’s medical record. This shall include, but not be limited to, the date, pain rating, treatment plan, and resident response”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.]
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Seite: 14-15
Zitat (Originalzitat) “Document pain in a visible place that can be used by other health care providers. This may be where vital signs are documented or on a separate pain flowsheet. Information important to document includes: date; time; pain intensity rating; quality (e.g., sharp, dull, burning etc.); location; onset and duration; comfort-function goal; analgesic information (e.g., drug, dose, route, frequency); other pain interventions; vital signs and side effects (APS, 2003; Arnstein, 2002; Faries et al., 1991; McCaffery & Pasero, 1999; O'Connor, 2003; VHA/DoD, 2002; Voigt et al., 1995).—B “ (See example of a pain flowsheet in Appendix B.)
Evidence-Grad: siehe Referenzen II-a – V-b Empfehlungsstärke: B
Referenzen: APS. American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (Fifth ed.). Glenview, Illinois: American Pain Society (APS). (V-b). Arnstein, P. (2002). Optimizing perioperative pain management. AORN Journal; 76: S. 82-818. (V-b). Faries, J.E., Mills, D.S., Goldsmith, K.W., Phillips, K.D., Orr, J. (1991). Systematic pain records and their impact on pain control. Cancer Nursing; 14: S. 306-313. (II-a). McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual (2nd ed.). St. Louis, MO: Mosby. (Vb). O'Connor, M. (2003). Pain management: improving documentation of assessment and intensity.Journal for Healthcare Quality; 25 (1): S. 17-22. (III-b). VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Seite: 53
Zitat (Originalzitat): “The **Nursing Outcomes Classification (NOC)** is a standardized classification of patient/client outcomes developed to evaluate the effects of nursing interventions. An outcome is a measurable individual, family, or community state, behavior or perception that is measured along a continuum and is responsive to nursing interventions (Moorhead et al., 2004). The outcomes are developed for use in all settings and can be used across the care continuum to follow patient outcomes throughout an illness episode or over an extended period of care. The expected outcomes of effective management of acute pain older adults include: □ Reduction in the incidence and severity of acute pain □ Reduction in morbidities associated with poorly controlled pain (e.g., cardiovascular stress, reduced pulmonary function, deep vein thrombosis, mood disorders). □ Minimization of preventable complications associated with pain management □ Improvement of function and enhancement of patient comfort and satisfaction.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Moorhead, S., Johnson, M., Maas, M. (ed.) (2004). Nursing Outcomes Classification (NOC). St. Louis, MO: Mosby.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?
Standardisierte Dokumentation, settingspezifisch wird empfohlen
Seite: 13, 46 (2002) & 5 (2007)
Zitat (Originalzitat): “Recommendation 10 Document on a standardized form that captures the person’s pain experience specific to the population and setting of care. Documentation tools will include: Initial assessment, comprehensive assessment and re-assessment. Monitoring tools that track efficacy of intervention (0-10 scale). [**] Grade of Recommendation =C “ “Recommendation 11 S. 13: Document pain assessment regularly and routinely on standardized forms that are accessible to all clinicians involved in care. Grade of Recommendation =C” “S. 46: The monitoring tool should be kept where the team members all have access to the information”
Evidence-Grad: Empfehlungsstärke: Grade of Recommendation =C
Referenzen: [**] Royal College of Nursing (1999). Clinical practice guidelines - The recognition and assessment of acute pain in children. Technical report. London: Royal College of Nursing.Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39. Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90.

Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research; 35 (4): S. 58-71.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.
[+++]
de Rond, M.E., de Wit, R., van Dam, F.S., Muller, M. J. (2000). A pain monitoring program for nurses: Effects on communication, assessment and documentation of patients' pain. Journal of Pain and Symptom Management, 20 (6), S. 424-439.
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical
Nursing, 13 (6b): S. 74-90.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?

Seite: 25 (2002) & 18 (2007)

Zitat (Originalzitat):
"Health care organizations must have documentation systems in place to support and reinforce standardized pain assessment and management approaches."

Evidence-Grad:nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation: C

Referenzen:
Alley, L. (2001). The influence of an organizational pain management policy on nurses' pain management practices. Oncology Nursing Forum; 28 (5): S. 867-874.
Dahl, J., Gordon, D., Ward, S., Skemp, M., Wochos, S., Schurr, M. (2003). Institutionalizing pain management: The post-operative pain management quality improvement project. The Journal of Pain; 4 (7): S. 361-371.

/_2011
Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.

Frage 29 Wie sollte das Schmerzassessment dokumentiert werden?

Seite: 11 (Teil I) & 45 (Teil II)

Zitat (Originalzitat): "3 u) Documenteer deze pijnmetingen in het zorgdossier zodat deze makkelijk toegankelijk zijn voor alle zorgverleners"

Deutsche Formulierung der Empfehlung: Die Ergebnisse der Schmerzmessungen/Erfassungen sollten in dem Patientendossier notiert werden, so dass diese für alle Versorgenden/Behandelnden einfach zugänglich sind.

Evidence-Grad Empfehlungsstärke: nicht ausgewiesen

Referenzen:
British Pain Society and British Geriatrics Society 'The assesment of pain in older people' 200, zie Hadjistavropoulos et al 2007

Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of American Geriatrics Society 50: S. 205-224.
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: S208
Zitat (Originalzitat): “On initial presentation or admission of any older person to any healthcare service, a healthcare professional should assess the patient for evidence of persistent pain. (IIB)”
Evidence-Grad: II Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 7-8 (2012)
Zitat (Originalzitat): “Every patient should be regularly and systematically evaluated for pain. The process described in the following steps should be conducted, at a minimum, at the following times: Upon a patient's admission to a LTC facility and at each quarterly and annual review; • Whenever a patient has an acute illness or injury or experiences a decline in function or a change in mood or cognition; • Whenever a patient exhibits unexpected social withdrawal or signs of depression; • Whenever vital signs are obtained (i.e., as the "fifth vital sign"); • At least daily, for patients with a known painful condition; and • Before and after administration of as-needed (PRN) analgesie medication.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 8 (2012)
Zitat (Originalzitat): “Evaluate the patient for pain upon admission, during periodic scheduled assessments, and whenever a change occurs in his or her condition (e.g., after a fall or other trauma or when a change occurs in the patient's behavior, daily routines, or mental status).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 8 (2012)
Zitat (Originalzitat): “Key times to observe pain behaviors and to inquire about the presence and intensity of pain induce during ambulation, bathing, dressing, meal time, recreational activities, therapy

sessions, transfers, turning and repositioning, continence care, and wound care.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA). Summary 2009 & Volltext 2012
Frage 30: Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 34 (2012)
Zitat (Originalzitat): “Reassess patients with pain regularly. During titration of treatment for acute pain, specify the intervals at which acute pain should be evaluated. At a minimum, reassess patients with acute pain daily until the pain is substantially controlled and a stable analgesic regimen has been established. Ideally, the effectiveness of an analgesic should be assessed at the time of its peak effect, usually 1 hour for oral opioids. Staff members should also assess or evaluate the degree of pain relief just before and after administration of analgesics. It is reasonable to assess pain as the fifth vital sign when collecting vital signs for other reasons. All caregivers should be continually vigilant for signs or symptoms suggesting pain during daily activities or with procedures or therapy that may cause pain. Systematic pain monitoring should be implemented - Everyday; - Every shift; - Before and after administration of analgesics; - Before, during, and after ADLs; and - With associated procedures or therapy that may cause pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 4
Zitat (Originalzitat): “Non Identification If pain is not identified during assessment on admission to residential care, it is recommended[3] that the issue of pain identification is raised again: - In the event of significant change in resident’s condition - At any time that pain is suspected - Every three months”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 Pain in Residential Aged Care Facilities – Management Strategies (2005).
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 7
Zitat (Originalzitat): “Both at rest and movement-based (for example, duringtransfers) periods should be included in the assessment protocol when observational pain measures are undertaken.”
Evidence-Grad Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T.; Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 110
Zitat (Originalzitat): “Hadjistavropoulos et al.[15] also recommended obtaining baseline pain measurements for the individual in order to measure fluctuations in pain scores over time. Whenever, possible the same assessor should be used across assessment times.Hadjistavropoulos et al.,[15] as well as Herr et al.,[72] highlighted the importance of assessing pain during movement-based tasks and not simply when the older adult is at rest. “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 2 (3): S. S1–S43. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs.; 7: 44–52. doi:10.1016/j.pmn.2006.02.003

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 110
Zitat (Originalzitat): “Because of the high prevalence of pain among persons with dementia, it is recommended that older adults in long-term care be assessed for pain within 24 hours of admission and no less than once a week for the duration of their stay.74 In addition, it has been recommended that pain assessment tools be used regularly to monitor the efficacy of pain-management interventions.[74] “
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S. et al. (2009). Transforming long-term care pain management in North America: The policy-clinical interface. Pain Med;10: S. 506–520.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain 23(1): S1-S43.
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: S14
Zitat (Originalzitat): “Note also that many pain conditions may not hurt when the older person is at rest, and so assessment during movement or the performance of daily activities is important, particularly for those with memory impairment.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen:

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 5
Zitat (Originalzitat): “B. A Pain Rating Scale shall be completed and documented, at a minimum, in the following circumstances: 1. as part of the Pain Screening upon admission 2. upon re-admission 3. upon day of planned discharge (send a copy with the resident) 4. when warranted by changes in the resident’s condition or treatment plan 5. self reporting of pain and/or evidence of behavioral cues indicative of the presence of pain 6. to identify and monitor the level of pain and/or the effectiveness of treatment modalities until the resident achieves consistent pain relief or pain control”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 6
Zitat (Originalzitat): “PAIN ASSESSMENT (…) B. In nursing facilities, a complete Pain Assessment shall be completed at the time of the quarterly MDS if pain has been recorded. C. In assisted living facilities, the semi-annual wellness nursing assessment shall include a pain rating scale. If greater than 0, a Pain Assessment shall be completed. D. In residential health care and adult day health services, a Pain Assessment shall be completed when pain is reported, and should be completed at least annually thereafter”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 30 Wann sollte ein Assessment von Schmerzen stattfinden?
Seite: 12
Zitat (Originalzitat): “A baseline pain assessment is necessary prior to a known painful event, such as surgery or diagnostic procedure(...)”
Evidence-Grad: siehe Referenzen IV-a – V-a Empfehlungsstärke: D
Referenzen: AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a). APS. American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (Fifth ed.). Glenview, Illinois: American Pain Society (APS). (V-b). Kehlet, H.M. (1989). Surgical Stress: The role of pain and analgesia. British Journal of Anaesthesia; 63: S. 189-195. (IV).

Pasero, C., Reed, B.A., McCaffery, M. (1999c). Pain in the elderly. In McCaffery, M., Pasero, C. (ed.). Pain: Clinical Manual for Nursing Practice (2nd ed.): S. 674-710. St. Louis, MO:Mosby. (V-a).
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

5.3 Zitate zur Beantwortung der klinisch relevanten Fragen zum Bereich Verlauf der Erfassung von Schmerz bei älteren Menschen in der vollstationären Altenhilfe

Frage 31: Welche Kriterien müssen erfüllt sein, damit eine Verlaufserfassung durchgeführt werden kann?

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.
Frage 31: Welche Kriterien müssen erfüllt sein, damit eine Verlaufserfassung durchgeführt werden kann?
Seite:15
Zitat (in Originalsprache): “At a minimum, the care plan should incorporate the following elements: • The pain scale that should be used consistently to measure the patient' s pain and the recommended frequency of reassessments using this scale (e.g., 1 hour after administration of the pain medication). The scale being used should be clearly 'identified to all staff members caring for the patient; • The extent to which underlying causes can be addressed and the likely impact on pain symptoms of doing so; • The patient's goals for pain management, including the desired level of pain reduction or acceptable level of pain to be achieved by implementing the plan; • Measurable patient-centered functional outcomes (e.g., the ability to participate in a favorite activity, to visit with family, to ambulate to the dining room, or to sleep through the night); • Frequency with which the patient' s progress and responses to attempted pain management need to be monitored and who will do the monitoring; • Comfort measures to be implemented by nurses and other staff members to enhance the effectiveness of the plan; • Potential adverse effects of treatments and the recommended frequency of monitoring for those effects along with interventions to lessen or eliminate any negative outcomes that could decrease plan effectiveness; and • For cognitively impaired patients, documentation that the care plan was discussed with and agreed upon by the health care proxy.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 31: Welche Kriterien müssen erfüllt sein, damit eine Verlaufserfassung durchgeführt werden kann?
Seite: 7
Zitat (in Originalsprache): “A uni-dimensional pain assessment instrument is used to continue to evaluate pain intensity and the response to treatment once a comprehensive assessment has been completed.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies
Frage 31: Welche Kriterien müssen erfüllt sein, damit eine Verlaufserfassung durchgeführt werden kann?
Seite: 7

Zitat (in Originalsprache): “Once a comprehensive pain assessment is completed, a uni-dimensional pain assessment scale can be used for ongoing evaluation of pain intensity and the response to treatment.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: S210
Zitat (in Originalsprache): “Patients with persistent pain should be reassessed regularly (…).”
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: S218
Zitat (in Originalsprache): “Patients taking analgesic medications should be monitored closely.”
Evidence-Grad: I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA)
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite:4
Zitat (in Originalsprache): “Evaluate the patient for pain upon admission, during periodic scheduled assessments, and whenever a change occurs in his or her condition (e.g., after a fall or other trauma; when a change occurs in the patient's behavior, daily routines, or mental status).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 7
Zitat (in Originalsprache): “Once a comprehensive pain assessment is completed, a uni-dimensional pain assessment scale can be used for ongoing evaluation of pain intensity and the response to treatment. Uni-dimensional assessments can be performed daily, or more frequently, if the information gained will help guide treatment. Both a Numeric Rating Scale (NRS) and a Verbal Descriptor Scale (VDS) should be available and one or the other chosen on the basis of utility and resident preference. A reasonable approach may be to try an NRS first and if it is not well understood, to offer a VDS.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 21 f.

Zitat (in Originalsprache): “Medications should, generally, be commenced at a low dose, monitored and titrated slowly as required. More frequent monitoring, dose adjustment and higher doses should be implemented for severe pain as recommended in the Australian Pharmaceutical Advisory Council’s Guidelines for Medication Management in Residential Aged Care Facilities 2002.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Guidelines for medication management in residential aged care facilities. www.health.gov.au/internet/wcms/Publising.nsf/Content/nmp-pdf-resguide-cnt.htm/

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007) A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 4
Zitat (in Originalsprache): Keine explizite Aussage, aber Hinweis zu Alter und Assessment “Any health assessment of older people (> 65 years) should aim to identify the presence of pain.“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 110
Zitat (in Originalsprache): “(…) older adults in long-term care (…).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs; 7: S. 44–52. doi:10.1016/j.pmn.2006.02.003

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 5-6
Zitat (in Originalsprache): “B. A Pain Rating Scale shall be completed and documented, at a minimum, in the following circumstances: 1. as part of the Pain Screening upon admission 2. upon re-admission 3. upon day of planned discharge (send a copy with the resident) 4. when warranted by changes in the resident’s condition or treatment plan 5. self reporting of pain and/or evidence of behavioral cues indicative of the presence of pain 6. to identify and monitor the level of pain and/or the effectiveness of treatment modalities until the resident achieves consistent pain relief or pain control C. If the resident is cognitively impaired or non-verbal, the facility shall utilize pain rating scales for the cognitively impaired and non-verbal resident. Additionally, the facility shall seek information from the resident’s family, caregiver or other representative, if available and

known to the facility. (…) D. In residential health care and adult day health services, a Pain Assessment shall be completed when pain is reported, and should be completed at least annually thereafter.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite:
Zitat (in Originalsprache): nicht ausgewiesen
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 5 (2007)
Zitat (in Originalsprache): „(…) in persistent pain situations.“
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services. Royal College of Nursing (RCN) (1999). Clinical practice guidelines - The recognition and assessment of acute pain in children. Technical report. London: Royal College of Nursing. Institute for Clinical Systems Improvement (ICSI) (2001). Health care guideline: Assessment and management of acute pain. Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39. Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90. van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609. van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491. Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 32: Für welche Bewohner ist eine Verlaufserfassung erforderlich?
Seite: 12 (2007) & S. 62 (2002)
Zitat (in Originalsprache): “Monitor persons taking opioids, recognizing that opioids used for people not in pain, or in

doses larger than necessary to control the pain, or when they have not been titrated appropriately, can slow or stop breathing.”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: A
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1992). Acute pain management: Operative or medical procedures and trauma. Clinical practice guideline; (1): Rockville, MD: Agency for Health Care Policy and Research, Public Health Services, U.S. Department of Health and Human Services. Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services. American Pain Society (APS) (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS). Cherney et al. (1995) (keine Detailangaben/Zuordnung nicht möglich) de Stoutz, N., Bruera, E., Suarez-Almazor, M. (1995). Opioid rotation for toxicity reduction in terminal cancer patients. Journal of Pain and Symptom Management; 10 (5): S. 378-384.

Frage 33: Welchen Nutzen hat eine Verlaufserfassung von Schmerzen im Vergleich zu keiner Verlaufserfassung für die ausgewählte Population?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 33: Welchen Nutzen hat eine Verlaufserfassung von Schmerzen im Vergleich zu keiner Verlaufserfassung für die ausgewählte Population?
Seite: S211 & S218
Zitat (in Originalsprache): “It is rare that any two patients respond with exactly the same degree of relief or side effects to the same pain relieving-drug. Therefore, the individually tailored therapeutic trials are the hallmark of effective pharmacotherapy for persistent pain. Titrating drugs while monitoring therapeutic and adverse effects should be done with consideration for specific subjective and objective endpoints.” „Clinical endpoints should be decreased pain, increased function, and improvements in mood and sleep, not decreased drug dose.“ (S. 218). IIIB
Evidence-Grad: III Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 33: Welchen Nutzen hat eine Verlaufserfassung von Schmerzen im Vergleich zu keiner Verlaufserfassung für die ausgewählte Population?
Seite: 107
Zitat (in Originalsprache): “In addition to improved scores on various assessment tools, evidence of more effective pain management can be observed in areas such as greater participation in activities, improved sleep, reduced behavioural disturbance, improved ability to ambulate, and improved social interactions.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs; 7: S. 44-52. doi:10.1016/j.pmn.2006.02.00.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 33: Welchen Nutzen hat eine Verlaufserfassung von Schmerzen im Vergleich zu keiner Verlaufserfassung für die ausgewählte Population?
Seite: S23
Zitat (in Originalsprache): Hinwies auf Schmerztagebüchern, die hier indirekt Antwort gibt: “A helpful tool in gathering information about the older persons’ pain and response to treatment particularly in clinical trials and community setting is the pain diary. Diaries have been shown to be valid and reliable measures of pain severity and activity[145 ,146]. Pain diaries are particularly useful for identifying related factors that exacerbate (…) or decrease pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen:

[145.] Follick, M.J., Ahern, D.K., Laser-Wolston, N. (1984). Evaluation of a daily activity diary for chronic pain patients. Pain; 19: S. 373–382.
[146.] Schumacher, K.L., Koresawa, S., West, C. et al. (2002).The usefulness of a daily pain management diary for outpatients with cancer-related pain. Oncol Nurs Forum; 29: S. 1304–1313.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 33: Welchen Nutzen hat eine Verlaufserfassung von Schmerzen im Vergleich zu keiner Verlaufserfassung für die ausgewählte Population?
Seite: 45 (2002)
Zitat (in Originalsprache): “Clinicians should be aware of common pain syndromes: this prompt recognition may hasten therapy and minimize the morbidity of unrelieved pain.”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: Agency for Health Care Policy and Research (1994). Management of cancer pain. Clinical practice guideline, Number 9. (rev 2000). AHCPR Publication Number 94-0592. Rockville, MD: Agency for Health Care Policy and Research, Public Health Services. U.S. Department of Health and Human Services.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S210
Zitat (in Originalsprache): “Patients with persistent pain should be reassessed regularly for improvement, deterioration, or complications.”
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S210
Zitat (in Originalsprache): “A The use of a pain log or diary with regular entries for pain intensity, medication use, mood, response to treatment, and associated activities should be considered.”
Evidence-Grad: III Empfehlungsstärke: C
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S210
Zitat (in Originalsprache): “B The same quantitative pain assessment scales should be used for initial and follow-up assessments.”
Evidence-Grad III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S211
Zitat (in Originalsprache): “C Reassment should include evaluation of analgesic and nonpharmacologic interventions, side effects, and compliance issues.”
Evidence-Grad III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S211

Zitat (in Originalsprache): “D. Reassment should consider patient preferences in assessment and treatment revisions”.
Evidence-Grad: III Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S216
Zitat (in Originalsprache): “Monitoring the side effects of opioid therapy should focus on neurologic, gastrointestinal, and cognitive-behavioral effects. These include gait disturbances (ataxia), dizziness, falls, pruritus, constipation (a, b), abdominal distention or discomfort, nausea, sedation, and impaired concentration.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: a: Derby, S., Portenoy, R.K. (1997). Assessment and management of opoid-induced constipation. In: Portenoy, RK, Bruera, E. (Hrsg): Topics in Palliative Care; 1: S. 95 – 112. New York: Oxford University Press. b: Walsh, T.D. (1999): Prevention and opioid side effects. In: J Pain Symptom Management 5: S. 363 - 367

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S218
Zitat (in Originalsprache): “A. Patients should be reevaluated frequently for drug efficacy and side effects during initiation, titration, or any change in dose of analgesic medications.”
Evidence-Grad: I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S218
Zitat (in Originalsprache): “B. Patients should be reevaluated regularly for drug efficacy and side effects throughout long-term analgesic drug maintenance.”
Evidence-Grad III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S218
Zitat (in Originalsprache): “1 Patients on long-term opioid therapy should be evaluated periodically for inappropriate or

dangerous drug-use patterns.”
Evidence-Grad III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S218
Zitat (in Originalsprache): “2. Patients on long-term NSAIDs should be periodically assessed for symptoms or signs of gastrointestinal blood loss, renal insufficiency, edema, hypertension, and drug-drug or drug-disease interactions.”
Evidence-Grad I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S218
Zitat (in Originalsprache): “Patients should be closely monitored for side effects.”
Evidence-Grad I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S218
Zitat (in Originalsprache): “X. Clinical endpoints should be decreased pain, increased function, and improvements in mood and sleep, not decreased drug dose.”
Evidence-Grad III Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA)
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 34
Zitat (in Originalsprache): “Review and reassess the following: l Characteristics of pain (e.g., frequency, intensity). In cognitively impaired patients, review and assess behavioral signs and symptoms that suggest pain. l The impact of pain on the patient's mood, ADLs, sleep, and quality-of-life measures. l The conditions or diagnoses associated with the patient's pain. l The treatment plan and effectiveness of current medications and CAM treatments. l The adverse effects of analgesic drugs, CAM treatments, and nonpharmacologic therapies.”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 7
Zitat (in Originalsprache): “A uni-dimensional pain assessment instrument is used to continue to evaluate pain intensity and the response to treatment once a comprehensive assessment has been completed. Both a Numeric Rating Scale and a Verbal Descriptor Scale should be available and one or the other chosen on the basis of utility and resident preference.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 16
Zitat (in Originalsprache): “Repeated assessments of pain are critical to effective pain management. It is important to evaluate and document changes in a resident’s pain intensity, mood and function including the effect of treatment over time.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RCP_2007 Royal College of Physicians, British Geriatric Society et al. (2007). The Assessment of Pain in Older People: National Guidelines. Concise guidance to good practice series No 8. London, Royal College of Physicians.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 5-6
Zitat (in Originalsprache): **“7 Re-evaluation Grade C** Once a suitable scale has been identified, serial assessment should be undertaken using the same instrument to evaluate the effects of treatment.”
Evidence-Grad: nicht ausgewiesen Empfehlungsstärke: C
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 7 & 20
Zitat (in Originalsprache): **“GUIDANCE** **1. Assessing for the presence of pain** **i. Screening/Care planning** **Evidence based statement:** **Self reporting of pain is the gold standard method for identifying pain.** Pain has been referred to as ‘The Fifth Vital Sign™’. This emphasises the importance of considering, measuring and monitoring the presence of pain systematically. It is important to

encourage all health care workers to include a routine screening question to assess for the presence of pain in assessments of older people. In the context of the single assessment process proposed in the National Service Framework for Older People18 this would include the overview assessments as well as more detailed levels of assessment.

Recommendation:

- Any health assessment of older people should include asking whether they experience pain
- The single assessment process should include a question seeking to identify the presence of pain.

5. Algorithm for assessment of pain in older people

The evidence provided in this guidance document suggests that two different approaches to pain assessment are required in the older person, depending on their ability to communicate. The algorithm **(appendix 3)** illustrates two different pathways: one for those who are able to communicate successfully; and another for those who are not."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

Pain: The Fifth Vital SignTM < http://www.ampainsoc.org/advocacy/fifth.htm> www.ampainsoc.org/advocacy/fifth.htm

Hadjistavropoulos et al._2010

Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?

Seite: 107

Zitat (in Originalsprache):

"Baseline scores should be collected for each individual (ideally on a regular basis which would allow for the examination of unusual changes from the persons typical pattern of scores).

4. Patient history and physical examination results should be taken into consideration.

5. If assessments are to be repeated over time, assessment conditions should be kept constant (e.g., use the same assessment tool, use the same assessor where possible and conduct pain assessment during similar situations).

6. Pain-assessment results should be used to evaluate the efficacy of pain management interventions.

7. Knowledgeable informants (e.g., caregivers) should be asked about typical pain behaviours of the individual.

8. Other aspects of the pain experience should also be evaluated including environmental factors, psychological functioning and social environment."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:

[15.] Hadjistavropoulos, T., Herr, K. et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain; 23 (1): S. S1-S43.

[72.] Herr, K., Coyne P.J., Key, T., Manworren, R., McCaffrey, M., Merkel, S., Pelosi-Kelly, J., Wild, L. (2006). American Society for Pain Management Nursing. Pain assessment in the nonverbal patient: position statement with practice Recommendations.

Ggf. weitere Bemerkungen

Es wird impliziert, dass die zur Baseline genannten Informationen auch im Verlauf zu erfassen sind. Eine Differenzierung für Verlaufsinformationen erfolgt nicht. Die Aussagekraft ist in dieser Hinsicht begrenzt.

Hadjistavropoulos et al._2007

Hadjistavropoulos, T., Herr, K. et al. (2007). "An interdisciplinary expert consensus statement on assessment of pain in older persons." Clinical Journal of Pain; 23 (1): S. S1-S43.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S3
Zitat (in Originalsprache): “It is imperative that reassessments of pain and effectiveness of treatments be conducted using the same tools as in the original assessment. Pain tools are not interchangeable and do not represent comparable findings.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S5
Zitat (in Originalsprache): Grafik “Domains included in a comprehensive pain assessment Initial determination and / or ongoing monitoring of pain” “Self reports of pain: • Unidimensional measures • Multidimensional measures Behavioural measures of pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Bezug wird hergestellt zu IMMPACT – Empfehlungen Turk, D.C., Dworkin, R.H., Allen, R.R. et al. (2003). Core outcome domains for chronic pain clinical trials: IMMPACT recommendations. Pain; 106: S. 337–345. Dworkin, R.H., Turk, D.C., Farrar, J.T. et al. (2005). Core outcome measures for chronic pain clinical trials: IMMPACT recommendations. Pain; 113: S. 9–19.

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S7 (Table 6)
Zitat (in Originalsprache): “Monitor the effects of the pharmacotherapeutic regimen.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: S4 (Table 3)
Zitat (in Originalsprache): “If assessment tools are used to monitor pain levels over time, they must be used under consistent circumstances (e.g. during a structured program pf physiotherapy, over the course of a a typical evening).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?

Seite: 46

Zitat (in Originalsprache):
"Establish regular reassessment and documentation of pain, including intensity, location, quality and duration, and impact of pain using selected assessment tools. Systematic and regular reassessment of pain should be established in order to identify the efficacy of the pain intervention activities chosen and to determine any need for revision in the pain management plan (Chibnall & Tait, 2001; Pasero et al., 1999a; VHA/DoD, 2002).**— C "**

Evidence-Grad: III-a – V-b
Empfehlungsstärke: C

Referenzen:
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–186. (III-a).
Pasero, C., Gordon, D.B., McCaffery, M., Ferrell, B.R. (1999a). Building institutional commitment to improving pain management. In McCaffery, M., Pasero, C. (ed.), Pain: Clinical Manual for Nursing Practice (2nd ed): S. 711-744. St. Louis, MO: Mosby. (V-b).
VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, 1 (1). Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?

Seite:45

Zitat (in Originalsprache):
"Evaluate the effectiveness of pain management interventions and revise plan as needed. Evaluation should include the following:

- Whether the comfort-function goal is being met (e.g., <4 on 0-10 scale to cough and deep breathe)
- Duration of pain relief
- Impact of pain on the patient's ability to perform functional requirements necessary for recovery
- Patient satisfaction with pain relief
- Side effects including nausea, cognitive change, urinary and bowel function."

Evidence-Grad: IV-a – V-b
Empfehlungsstärke: D

Referenzen:
AGS (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a).
APS American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (5th ed.). Glenview, Illinois: American Pain Society (APS). (V-b).
McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual (2nd ed.). St. Louis, MO: Mosby. (Vb).
VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?

Seite: 45 f.

Zitat (in Originalsprache): “Assess pain relief from pharmacological interventions.”
Evidence-Grad: III-a - Vb Empfehlungsstärke: C
Referenzen: Pasero, C., McCaffery, M. (2004b). Comfort-function goals. American Journal of Nursing; 104 (9): S. 77. (V-b). Cepeda, M.S., Africano, J.M., Polo, R., Alcala, R., Carr, D.B. (2003a). What decline in pain intensity is meaningful to patients with acute pain? Pain; 105 (1-2): S. 151-157. (III-a). Cepeda, M.S., Farrar, J.T., Baumgarten, M., Boston, R., Carr, D.B., Strom, B.L. (2003b). Side effects of opioids during short-term administration: effect of age, gender, and race. ClinicalPharmacology & Therapeutics; 74 (2): S. 102-112. (III-b). VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 45 f.
Zitat (in Originalsprache): “Ask about pain and observe nonverbal pain-related behaviors during transfers or patient care activities.”
Evidence-Grad: III-a Empfehlungsstärke: C
Referenzen: Feldt, K.S., Ryden, M.B., Miles, S. (1998a). Treatment of pain in cognitively impaired compared with cognitively intact older patients with hip-fracture. Journal of the American Geriatrics Society; 46 (9): S. 1079-1085. (III-a). Hadjistavropoulos, T., LaChapelle, D.L., MacLeod, F.K., Snider, B., Craig, K.D. (2000). Measuring movement-exacerbated pain in cognitively impaired frail elders. Clinical Journal of Pain; 16 (1): S. 54-63. (III-a). Raway, B. (1993). Pain behaviors and confusion in elderly patients with hip fracture (DISS). Washington, D.C.: The Catholic University of America. (III-a).

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 45 f.
Zitat (in Originalsprache): “Assess for presence of delirium that may develop during acute illness/post- operatively in older adults. Factors to assess include: perioperative medications, such as anticholinergics, meperidine, sedatives/hypnotics; opioids (too little may be as bad as too much); withdrawal from alcohol and benzodiazepines; inhaled anesthetic agents; hypoxemia; post-operative metabolic disturbances; sleep deprivation; unfamiliar environment; comorbid diseases; impaired vision/hearing; pain (…).”
Evidence-Grad: II-a – V-b Empfehlungsstärke: B
Referenzen: Adunsky, A., Levy, R., Mizrahi, E., Arad, M. (2002b). Exposure to opioid analgesia in cognitively impaired and delirious elderly hip fracture patients. Archives of Gerontology &

Geriatrics; 35 (3): S. 245-251. (III-a).
AGS (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50 (Suppl. 6): S. S205-S224. (IV-a).
Babel, K. (1997). Treating acute alcohol withdrawal. American Journal of Nursing; 97 (1): S. 22-23. (V-b).
Duggleby, W., Lander, J. (1994). Cognitive status and postoperative pain: Older adults. Journal of Pain & Symptom Management; 9 (1): S. 19-27. (III-a).
Egbert, A.M., Parks, L.H., Short, L.M., Burnett, M.L. (1990). Randomized trial of postoperative patient-controlled analgesia vs. intramuscular narcotics in frail elderly men. Archives of Internal Medicine; 150: S. 1897-1903. (II-a).
Gustafson, Y., Brännström, B., Norberg, A., Gustav, B., Winbald, B. (1991). Underdiagnosis and poor documentation of acute confusional states in elderly hip fracture patients. Journal of the American Geriatrics Society; 39: S. 760-765. (III-a).
Lynch, E.P., Lazor, M.A., Gellis, J.E., Orav, J., Goldman, L., Marcantonio, E.R. (1998). The impact of postoperative pain on the development of postoperative delirium. Anesthesia & Analgesia; 86 (4): S. 781-785. (II-b).
Morrison, R.S., Magaziner, J., Gilbert, M., Koval, K.J., McLaughlin, M.A., Orosz, G., Strauss, E., Siu, A.L. (2003a). Relationship between pain and opioid analgesics on the development of delirium following hip fracture. Journals of Gerontology Series A-Biological Sciences & Medical Sciences; 58 (1): S. 76-81. (II-a).
Pasero, C., Reed, B.A., McCaffery, M. (1999c). Pain in the elderly. In McCaffery, M., Pasero, C. (ed.). Pain: Clinical Manual for Nursing Practice (2nd ed.): S. 674-710. St. Louis, MO:Mosby. (V-a).
Rosenberg, J., Kehlet, H. (1993). Postoperative mental confusion: Association with postoperative hypoxemia. Surgery; 114: S. 76-81. (IV-a).
Rosenberg, J., Rosenberg-Adamsen, S., Kehlet, H. (1995). Post-operative sleep disturbance: Causes, factors and effects on outcome. European Journal of Anaesthesia; 12 (Suppl. 10): S. 28-30. (IV-b).
Strömberg, L., Lindgren, U., Nordin, C., Öhlen, G., Svensson, O. (1997). The appearance and disappearance of cognitive impairment in elderly patients during treatment for hip fracture. Scandinavian Journal of Caring Science; 11: S. 167-175. (III-a).
Williams-Russo, P., Urquhart, B.L., Sharrock, N.E., Charlson, M.E. (1992). Post-operative delirium: Predictors and prognosis in elderly orthopedic patients. Journal of the American Geriatrics Society; 40: S. 759-767. (II-a).
Williams, M.A., Campbell, E.B., Raynor Jr., W.J., Mlynarczyk, S.M., Ward, S.E. (1985a). Reducing acute confusional states in elderly patients with hip fractures. Nursing and Health, 8: S. 329-337. (II-a).

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?

Seite: 44 (2002) & 5 (2007)

Zitat (in Originalsprache): 2002:
_”8. The following parameters are included in the regular re-assessment of pain:
(Grade of Recommendation = C)
_ current pain intensity, quality and location;
_ intensity of pain at its worst in past 24 hours, at rest and on movement;
_ extent of pain relief achieved – response (reduction on pain intensity scale);
_ barriers to implementing the treatment plan;
_ effects of pain on ADL’s, sleep and mood;
_ side effects of medications for pain treatment (nausea, constipation);
_ level of sedation; and
_ strategies used to relieve pain, for example:
_ Analgesic doses taken regularly and for breakthrough pain
_ Non-pharmacological interventions:

_ Physical modalities
_ Cognitive/behavioural strategies
_ Rehabilitative strategies
_ Environmental changes
_ Reduction in anxiety.
2007:
8. The following parameters should be monitored on an ongoing basis in persistent pain situations:
■ current pain intensity, quality and location;
■ intensity of pain at its worst in past 24 hours, at rest and on movement;
■ extent of pain relief achieved – response (reduction on pain intensity scale);
■ barriers to implementing the treatment plan;
■ effects of pain on ADL's, sleep and mood;
■ adverse effects of medications for pain treatment (e.g., nausea, constipation);
■ level of sedation; and
■ strategies used to relieve pain, both pharmacological and non-pharmacological.
Grade of Recommendation = C „

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation = C

Referenzen:
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
Jensen, M.P., Chen, C. Brugger, A.M. (2002). Postsurgical pain outcome assessment. Pain; 99 (1-2): S. 101-109.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 34: Welche Informationen sind im Verlauf zu erfassen?

Seite: 62 (2002) & 12 (2007)

Zitat (in Originalsprache):
"Monitor persons taking opioids for potential toxicity when the person exhibits:
■ Unacceptable adverse effects such as, but not limited to, myoclonus, confusion, delirium refractory to prophylactic treatment.
■ In the presence of inadequate pain relief following appropriate dose titration."

Evidence-Grad: nicht ausgewiesen
Empfehlungsstärke: Grade of Recommendation = C

Referenzen:
Agency for Health Care Policy and Research (AHCPR) (1992). Acute pain management: Operative or medical procedures and trauma. Clinical practice guideline; (1): Rockville, MD: Agency for Health Care Policy and Research, Public Health Services, U.S. Department of Health and Human Services.
Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health

Services: U.S. Department of Health and Human Services.
American Pain Society (APS) (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS).
Cherney et al. (1995) (keine Detailangaben/Zuordnung nicht möglich)
de Stoutz, N., Bruera, E., Suarez-Almazor, M. (1995). Opioid rotation for toxicity reduction in terminal cancer patients. Journal of Pain and Symptom Management; 10 (5): S. 378-384.
Cepeda, MS., Carr, D.B., Miranda, N., Diaz, A., Silva, C. Morales, O. (2005). Comparison of morphine, ketorolac, and their combination for postoperative pain: Results from a large, randomized, double-blind trial. Anesthesiology; 103 (6): S. 1225-1232.

Verenso 2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 29 (Teil II)
Zitat (in Originalsprache): „3b: Bij de dagelijkse zorg dient aan kwetsbare ouderen zonder of met milde tot matige cognitieve/communicatieve beperkingen gevraagd te worden of zij pijn hebben. 3c: Bij de dagelijkse zorg dient bij kwetsbare ouderen met ernstige cognitieve/ communicatieve beperkingen daarnaast ook pijn te worden geobserveerd, liefst met hulp van verzorgenden en mantelzorgers.“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Verenso 2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) 2011 Chronische pijn bij kwetsbare ouderen.
Frage 34: Welche Informationen sind im Verlauf zu erfassen?
Seite: 29 (Teil II)
Zitat (in Originalsprache): „Voor zover de cognitieve/communicatieve mogelijkheden van de kwetsbare oudere dit toelaten, dient een volledige medische anamnese te worden afgenomen, inclusief een volledige pijnanamnese: wanneer de pijn begon, waar de pijn gelocaliseerd is, hoe erg de pijn is, het tijdsverloop, uitstraling van de pijn, factoren die de pijn verlichten of juist verergeren, de aard van de symptomen. Het ezelsbruggetje ALTIS kan hierbij behulpzaam zijn: aard, locatie, tijd, intensiteit, samenhang.“
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S210
Zitat (in Originalsprache): “Patients with persistent pain should be reassessed regularly (…).”
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S218
Zitat (in Originalsprache): “Patients taking analgesic medications should be monitored closely.”
Evidence-Grad: I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S218
Zitat (in Originalsprache): “A. Patients should be reevaluated frequently for drug efficacy and side effects during initiation, titration, or any change in dose of analgesic medications.”
Evidence-Grad: I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S218
Zitat (in Originalsprache): “B. Patients should be reevaluated regularly for drug efficacy and side effects throughout long-term analgesic drug maintenance.”
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S218
Zitat (in Originalsprache): “1 Patients on long-term opioid therapy should be evaluated periodically for inappropriate or

dangerous drug-use patterns.” Einzelheiten folgen
Evidence-Grad: III Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S218
Zitat (in Originalsprache): “2. Patients on long-term NSAIDs should be periodically assessed for symptoms or signs of gastrointestinal blood loss, renal insufficiency, edema, hypertension, and drug-drug or drug-disease interactions.”
Evidence-Grad: I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: S218
Zitat (in Originalsprache): “Patients should be closely monitored for side effects.”
Evidence-Grad: I Empfehlungsstärke: A
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA)
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 4
Zitat (in Originalsprache): “Evaluate the patient for pain upon admission, during periodic scheduled assessments, and whenever a change occurs in his or her condition (e.g., after a fall or other trauma; when a change occurs in the patient's behavior, daily routines, or mental status)”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 8
Zitat (in Originalsprache): “At least daily, for patients with a known painful condition; and (…). Before and after administration of as-needed (PRN) analgesie medication.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors

Association (AMDA); 48.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 34
Zitat (in Originalsprache): “Reassess patients with pain regularly. During titration of treatment for acute pain, specify the intervals at which acute pain should be evaluated. At a minimum, reassess patients with acute pain daily until the pain is substantially controlled and a stable analgesia regimen has been established. Ideally, the effectiveness of an analgesia should be assessed at the time of its peak effect, usually 1 hour for oral opioids. Staff members should also assess or evaluate the degree of pain relief just before and after admistration of analgesics. It is reasonable to assess pain as the fifth vital sign when collecting vital signs for other reasons. All caregivers should be continually vigilant for signs or symptoms suggesting pain during daily activities or with procedures or therapy that may cause pain. Systematic pain monitoring should be implemented .. Everyday; .. Every shift; .. Before and after administration of analgesics; .. Before, during, and after ADLs; and .. With associated procedures or therapy that may cause pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 4
Zitat (in Originalsprache): “If pain is not identified during assessment on admission to residential care, it is recommended that the issue of pain identification is raised again: • In the event of significant change in resident’s condition • At any time that pain is suspected • Every three months.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 13
Zitat (in Originalsprache): “Once a comprehensive pain assessment is completed, a uni-dimensional pain assessment scale can be used for ongoing evaluation of pain intensity and the response to treatment. Uni-dimensional assessments can be performed daily, or more frequently, if the information gained will help guide treatment. Both a Numeric Rating Scale (NRS) and a Verbal Descriptor Scale (VDS) should be available and one or the other chosen on the basis of utility and resident preference. A reasonable approach may be to try an NRS first and if it is not well understood, to offer a VDS.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 16

Zitat (in Originalsprache): “Repeated assessments of pain are critical to effective pain management. It is important to evaluate and document changes in a resident’s pain intensity, mood and function including the effect of treatment over time. The RVBPI, the Abbey or PAINAD scales can all be used for review and progressive assessment of pain. A formal scheduled review using the validated instrument may be more valuable than frequent, brief impressions. However, in some situations (for example, communicative residents undergoing a trial of treatment) a uni-dimensional intensity scale should be employed frequently as described above. Progress notes should also be used for significant observations and exception reporting, especially for non-communicative residents. These should trigger an additional formal review, using the recommended instrument, when needed.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 16
Zitat (in Originalsprache): **“Reassessment of pain control.** If a vulnerable elder is treated for a chronic painful condition, then he or she should be assessed for a response within six months because initial treatment is often incompletely successful, and reassessment may be needed to achieve the most favourable outcome.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Chodosh, J., Ferrell, B.A., Shekelle, P.G., Wenger, N.S. (2001). Quality indicators for pain management in vulnerable elders. Ann Intern Med;Oct; 16 (135 8 Pt 2): S. 731-35.

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007) A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 7 & 20
Zitat (in Originalsprache): **“5. Algorithm for assessment of pain in older people** The evidence provided in this guidance document suggests that two different approaches to pain assessment are required in the older person, depending on their ability to communicate. The algorithm **(appendix 3)** illustrates two different pathways: one for those who are able to communicate successfully; => if pain is reported/apparent? and another for those who are not.”=> observe for potential indicators of pain?”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: S.21-28
Ggf. weitere Bemerkungen: Es gibt keine konkreten Angaben zur zeitlichen Erfassung.

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 110
Zitat (in Originalsprache). “(…) it is recommended that older adults in long-term care be assessed for pain within 24 hours of admission and no less than once a week for the duration of their stay.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: [74.] Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S., Beland, F. (2009).Transforming long-term care pain management in North America: the polisclinical interface. Pain Med.; 10 (3): S. 506-20.
Ggf. weitere Bemerkungen: Eigenzitat

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 110
Zitat (in Originalsprache): "(…) regularly to monitor the efficacy of pain-management interventions."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S., Beland, F. (2009).Transforming long-term care pain management in North America: the polisclinical interface. Pain Med.; 10 (3): S. 506-20.
Ggf. weitere Bemerkungen: Eigenzitat

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 110
Zitat (in Originalsprache): "(…) ongoing assessment is warranted (…)."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S., Beland, F. (2009).Transforming long-term care pain management in North America: the polisclinical interface. Pain Med.; 10 (3): S. 506-20.

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 5
Zitat (in Originalsprache): "B. A Pain Rating Scale shall be completed and documented, at a minimum, in the following circumstances: 1. as part of the Pain Screening upon admission 2. upon re-admission 3. upon day of planned discharge (send a copy with the resident) 4. when warranted by changes in the resident's condition or treatment plan 5. self reporting of pain and/or evidence of behavioral cues indicative of the presence of pain 6. to identify and monitor the level of pain and/or the effectiveness of treatment modalities until the resident achieves consistent pain relief or pain control B. In nursing facilities, a complete Pain Assessment shall be completed at the time of the quarterly MDS if pain has been recorded. C. In assisted living facilities, the semi-annual wellness nursing assessment shall include a pain rating scale. If greater than 0, a Pain Assessment shall be completed. D. In residential health care and adult day health services, a Pain Assessment shall be completed when pain is reported, and should be completed at least annually thereafter."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr K, Bjoro K, Steffensmeier J, Rakel B. Acute pain management in older adults. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2006 Jul. 113 p. [469 references]
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite:46
Zitat (in Originalsprache): **“ Ask about pain and observe nonverbal pain-related behaviors during transfers or patient care activities** (Feldt et al., 1998a; Hadjistavropoulos et al., 2000; Raway, 1993).**—C “**
Evidence-Grad: Empfehlungsstärke: C
Referenzen:

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 46
Zitat (in Originalsprache): “Assess postoperative older adults around the clock and during rest, during activity, and through the nighttime when pain is often heightened. Ability to sleep does not indicate absence of pain”
Evidence-Grad: III-a - Vb Empfehlungsstärke: C
Referenzen: APS American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (Fifth ed.). Glenview, Illinois: American Pain Society (APS). (V-b). Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–186. Donovan, M., Dillon, P., McGuire, L. (1987). Incidence and characteristics of pain in a sample of medical-surgical inpatients. Pain; 30: S. 69-78. (III-a). Nelson, L., Taylor, F., Adams, M., Parker, D.E. (1990). Improving pain managment for hip fractured elderly. Orthopaedic Nursing; 9 (3): S. 79-83. (III-a). VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense.(IV-b)

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 46
Zitat (in Originalsprache) “Pain relief should be assessed 30 minutes after parenteral and 60 minutes after oral administration of pain medication (…).”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Cepeda, M.S., Africano, J.M., Polo, R., Alcala, R., Carr, D.B. (2003a). What decline in pain intensity is meaningful to patients with acute pain? Pain; 105 (1-2): S. 151-157. (III-a).

Cepeda, M.S., Farrar, J.T., Baumgarten, M., Boston, R., Carr, D.B., Strom, B.L. (2003b). Side effects of opioids during short-term administration: effect of age, gender, and race. ClinicalPharmacology & Therapeutics; 74 (2): S. 102-112. (III-b).
VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense.(IV-b)

Horgas et al_2008
Horgas A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.

Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?

Seite: 64 & 67

Zitat (in Originalsprache):
“Regular use of the PAINAD scale, along with other recommended assessments (such as monitoring any behavioral changes and attempting to obtain the patient’s report of pain4), will increase nurses’ confidence in using this tool, even though a range of behavioral cues may indicate pain in patients with severe dementia.”
"If pain is suspected (…).”

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen:
Best practice information on care of older adults: www.ConsultGeriRN.org.
American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). Clinical practice guidelines: The management of persistent pain in older persons. JAGS; 50: S. S205-S224. Available at http://www.americangeriatrics.org/products/positionpapers/persistent_pain_guide.shtml, from the American Geriatrics Society Web site, www.americangeriatrics.org.
Herr, K. (2002). Pain assessment in cognitively impaired older adults. AJN; 102 (12): S. 65-68.
Herr, K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: A state-of-the-science review. Journal of Pain and Symptom Management; 31 (2): S. 170-192.
Warden, V., Hurley, A.C., Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) Scale. Journal of the American Medical Directors Association; 4 (1): S. 9-15.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?

Seite: 44 (2002) & 5 (2007)

Zitat (in Originalsprache):
2002:
“Pain is reassessed on a regular basis according to the type and intensity of pain and the treatment plan. (Grade of Recommendation = C)
_ Pain is reassessed at each new report of pain and new procedure, when intensity increases, and when pain is not relieved by previously effective strategies.
_ Pain is reassessed after the intervention has reached peak effect (15-30 minutes after parenteral drug therapy, 1 hour after immediate release analgesic, 4 hours after sustained release analgesic or transdermal patch, 30 minutes after non-pharmacological intervention).
_ Acute post-operative pain should be regularly assessed as determined by the operation and severity of pain, with each new report of pain or instance of unexpected pain, and after each analgesic, according to peak effect time.”

2007
"7. Pain is reassessed on a regular basis according to the type and intensity of pain and the treatment plan.
■ Pain intensity and function (impact on activities) is reassessed at each new report of pain and new procedure, when intensity increases, and when pain is not relieved by previously effective strategies.
■ Effectiveness of intervention (both pharmacological and non-pharmacological) is reassessed after the intervention has reached peak effect (e.g., for opioids: 15-30 minutes after parenteral opioid therapy; 1 hour after immediate release analgesic).
■ Acute post-operative pain should be regularly assessed as determined by the operation and severity of pain, with each new report of pain or instance of unexpected pain, and after each analgesic, according to peak effect time."
Grade of Recommendation = C

Evidence-Grad und/oder Empfehlungsstärke: C

Referenzen:
American Pain Society. (2005). Guideline for the management of cancer pain in adults and children. Glenview (IL): American Pain Society (APS).
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing; 13 (6b): S. 74-90.
Jensen, M.P., Chen, C. Brugger, A.M. (2002). Postsurgical pain outcome assessment. Pain; 99 (1-2): S. 101-109.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?

Seite: 46

Zitat (in Originalsprache):
"Adjust postoperative pain reassessment schedule to the patient's situation:
• Immediate postanesthesia period: every 5-10 minutes.
• First 24 hour postoperative period: every 1-2 hours
• Subacute postoperative period: every 2-4 hours
• If pain is well controlled after 24 hours: every 8 hours (with vital signs)"

Evidence-Grad und/oder Empfehlungsstärke: C

Referenzen:
Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–186.
Pasero, C., Gordon, D.B., McCaffery, M., Ferrell, B.R. (1999a). Building institutional commitment to improving pain management. In McCaffery, M., Pasero, C. (ed.), Pain: Clinical Manual for Nursing Practice (2nd ed): S. 711-744. St. Louis, MO: Mosby. (V-b).
VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, 1 (1). Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 62 (2002) & 12 (2007)
Zitat (in Originalsprache): “Evaluate the efficacy of pain relief with analgesics at regular intervals and following a change in dose, route or timing of administration. (…)”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1992). Acute pain management: Operative or medical procedures and trauma. Clinical practice guideline; (1): Rockville, MD: Agency for Health Care Policy and Research, Public Health Services, U.S. Department of Health and Human Services. Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services. Cherney et al. (1995) (keine Detailangaben/Zuordnung nicht möglich) de Stoutz, N., Bruera, E., Suarez-Almazor, M. (1995). Opioid rotation for toxicity reduction in terminal cancer patients. Journal of Pain and Symptom Management; 10 (5): S. 378-384.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 49 (2002)
Zitat (in Originalsprache): “Pain management should be evaluated at point of transfer (transmission) in the provision of services to ensure that optimal pain management is achieved and maintained.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services.

Verenso 2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 35: Wie ist die Verlaufserfassung zeitlich zu gestalten?
Seite: 29 (Teil II)
Zitat (in Originalsprache): „3b: Bij de dagelijkse zorg dient aan kwetsbare ouderen zonder of met milde tot matige cognitieve/communicatieve beperkingen gevraagd te worden of zij pijn hebben. 3c: Bij de dagelijkse zorg dient bij kwetsbare ouderen met ernstige cognitieve/ communicatieve beperkingen daarnaast ook pijn te worden geobserveerd, liefst met hulp van verzorgenden en mantelzorgers.“
Deutsche Formulierung der Empfehlung: In der täglichen Versorgung sollten gebrechliche Ältere ohne und mit leichten bis mittelschweren kognitiven und Kommunikationseinschränkungen gefragt werden, ob sie Schmerzen haben. In der täglichen Versorgung sollten gebrechliche Ältere mit schweren kognitiven und Kommunikationseinschränkungen auf Anzeichen von Schmerz beobachtet werden. Günstigstenfalls unter zu Hilfenahme der Pflegenden und pflegenden Angehörigen.
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 36: Wer sollte diese Informationen erfassen?

Keine der nachfolgenden Aussagen bezieht sich spezifisch auf die Verlaufsinformationen. Es handelt sich vielmehr um allgemeine Aussagen über die Zuständigkeit für die Schmerzerkennung und Schmerzerfassung. Streng genommen machen die ausgewerteten Leitlinien also keine spezifische Aussage dazu, wer Verlaufsinformationen erfassen soll.

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA)
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 4
Zitat (in Originalsprache): "Conduct an initial review to determine whether the characteristics and causes of the patient's pain have been identified. Appropriate members of the interdisciplinary team should: (…)"
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 34
Zitat (in Originalsprache): "Nursing assistants and other direct caregivers, who spend the most time with patients from day to day, are well placed to monitor patients' pain. They should be encouraged to monitor for pain during ADLs and when providing personal care and to report patient statements or observed behaviors that indicate pain. Such reports should prompt timely re-evaluation."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 7
Zitat (in Originalsprache): "Multidisciplinary collaboration between doctors, nurses, physiotherapists and other care staff is the key to effective pain assessment and management."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007). A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 6
Zitat (in Originalsprache): "All health care professionals, carers and family, should be alert to the possible presence of pain. Health care professionals should be in the possession of the skills and tools needed to assess pain."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RCP_2007 Royal College of Physicians, British Geriatric Society, et al. (2007). The Assessment of Pain

in Older People: National Guidelines. Concise guidance to good practice series No 8. London, Royal College of Physicians.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 7
Zitat (in Originalsprache): “All healthcare professionals, including those in primary care, hospitals and care home settings (…).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 107
Zitat (in Originalsprache): “If assessments are to be repeated over time, assessment conditions should be kept constant (e.g., use the same assessment tool, use the same assessor where possible and conduct pain assessment during similar situations).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: [15.] Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Lynn Beattie, B., Chibnall, J.T., Craig, K.D., Ferrell, B., Ferrell, B., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S.J., Harrison, E.L., Katz, B., Keefe, F.J., Lieber, S.J., Lussier, D., Schmader, K.E., Tait, R.C., Weiner, D.K., Williams ,J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons Clinical Journal of Pain; 23 (Supplement): S. S1-S43. Herr, K., Coyne, P.J., Key, T., Manworren, R., McCaffery, M., Merkel, S. et al. (2006). Pain assessment in the nonverbal patient: position statement with clinical practice recommendations. Pain Manag Nurs.; 7: 44–52. doi:10.1016/j.pmn.2006.02.003
Anmerkung zur Aktualität der Referenzen /z. b alte Quell LL/Empfehlungen (bitte Jahrgang der ursprünglichen Empfehlung angeben): 2006/2007
Ggf. weitere Bemerkungen In der Leitlinie werden nur Physiotherapeuten explizit erwähnt. Es wird gefordert, dass sie generell stärker einzubinden sind, insbesondere bei Protokollen zur Schmerzeinschätzung die bestimmte Bewegungssequenzen enthalten (MOBID). Diese Empfehlung bezieht sich nicht explizit auf den Verlauf.

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 5
Zitat (in Originalsprache): “To provide professional staff with standards of practice that will assist them in the effective assessment, monitoring and management of the resident’s pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Horgas et al._2008 Horgas A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 63

Zitat (in Originalsprache): “A trained nurse or other health care worker can use the scale in less than five minutes of observation.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Best practice information on care of older adults: www.ConsultGeriRN.org. American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). Clinical practice guidelines: The management of persistent pain in older persons. JAGS; 50: S. S205-S224. Available at http://www.americangeriatrics.org/products/positionpapers/persistent_pain_guide.shtml, from the American Geriatrics Society Web site, www.americangeriatrics.org. Herr, K. (2002). Pain assessment in cognitively impaired older adults. AJN; 102 (12): S. 65-68. Herr, K., Bjoro, K., Decker, S. (2006). Tools for assessment of pain in nonverbal older adults with dementia: A state-of-the-science review. Journal of Pain and Symptom Management; 31 (2): S. 170-192. Warden, V., Hurley, A.C., Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) Scale. Journal of the American Medical Directors Association; 4 (1): S. 9-15.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 5 (2007)
Zitat (in Originalsprache): Kommentar zu Empfehlung 7. “The wording of the recommendation has been changed to emphasize the need for the nurse to conduct a reassessment of pain intensity/severity following implementing a pain intervention (either pharmacological or non-pharmacological) to determine its efficacy.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 28 (2002)
Zitat (in Originalsprache): “The guideline contains recommendations for best nursing practices in the assessment and management of pain for Registered Nurses (RNs) and Registered Practical Nurses (RPNs).”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen
Anmerkung zur Aktualität der Referenzen /z. b alte Quell LL/Empfehlungen (bitte Jahrgang der ursprünglichen Empfehlung angeben):
Ggf. weitere Bemerkungen Angabe zur Zielgruppe der Leitlinie allgemein, nicht spezifisch für die Verlaufskontrolle.

Verenso 2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 27 (Teil II)
Zitat (in Originalsprache): „Volledige beoordeling van pijn gebeurt idealiter multidimensioneel en multidisciplinair. Alle

zorgverleners en de mantelzorgers van de patiënt zijn daarbij van belang.“
Deutsche Formulierung der Empfehlung: Eine vollständige Beurteilung von Schmerz geschieht idealerweise multidimensionell und multidisziplinär. Alle Pflegenden und pflegenden Angehörigen sind dabei von Belang.
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Herr, K., Turk, D.C., Fine, P.G., Dworkin, R.H., Helme, R. et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. Clin J Pain; 23: S. S1-S43.
Ggf. weitere Bemerkungen: Zitat bezieht sich allgemein auf die Zuständigkeit für die Schmerzanamnese; im Kontext der Leitlinie scheint Verlaufserfassung gemeint zu sein.

Verenso 2011 Verenso (Vereniging van specialisten ouderengeneeskunde en sociaal geriaters) (2011). Chronische pijn bij kwetsbare ouderen.
Frage 36: Wer sollte diese Informationen erfassen?
Seite: 31 (Teil II)
Zitat (in Originalsprache): „Mantelzorgers kunnen, naast professionele verzorgenden, toegevoegde waarde hebben bij het vaststellen van pijn.“
Deutsche Formulierung der Empfehlung: Pflegende Angehörige können, neben professionell Pflegenden, Schmerz feststellen
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: S211
Zitat (in Originalsprache): “D. Reassment should consider patient preferences in assessment and treatment revisions.”
Evidence-Grad: III Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AGS 2002 AGS Panel on Persistent Pain in Older Persons (2002). The management of persistent pain in older persons. Journal of the American Geriatrics Society; 50: S. S205-S224.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: S218
Zitat (in Originalsprache): “X. Clinical endpoints should be decreased pain, increased function, and improvements in mood and sleep, not decreased drug dose.”
Evidence-Grad III Empfehlungsstärke: B
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: i
Zitat (in Originalsprache): “Monitoring means reviewing the course of a condition or situation as a basis for deciding to continue, change, or discontinue interventions.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 35
Zitat (in Originalsprache): **“STEP 15** Adjust treatment as necessary. On the basis of the findings in Step 14, determine whether revision of the patient's care plan is indicated. If it is, prepare a revised care plan that recommends appropriate medications and complementary therapies. Explain the reasons for the proposed treatment changes to the patient and family or health care proxy. Consider tapering the patient's analgesic medication if the cause of his or her pain has been identified and addressed and is expected to improve (e.g., recovery from surgery). The timing of any medication reduction is a matter of clinical judgment. When adjusting the

treatment, generally avoid adding multiple opioids; rather, use careful titration of a single scheduled, long-acting opioid with the availability of a short-acting opioid for breakthrough pain. Remember to concomitantly increase the dose of the short-acting opioid when the dose of the long-acting opioid is increased. Repeat Steps 14 and 15 as frequently as is appropriate for the patient." **"STEP 16** Is rain controlled? Review and repeat the steps in this guideline as appropriate until the patient' s pain is controlled or it is determined that no further improvement is likely. Parameters that indicate poorly controlled pain (individualized to each patient) could include pain that is consistently greater than 6 on a 10-point scale or pain that interferes with the patient's quality of life and function. When patients have pain that is unresponsive to the management steps outlined in this guideline and the practitioner is uncomfortable with treating the pain more aggressively, the practitioner should consider consulting with a pain specialist or a geriatrician, neurologist, physiatrist, or palliative medicine practitioner. In some patients, pain may relate to a somatoform disorder or may have a spiritual or existential component. When these conditions are suspected or when pain does not respond adequately to other, more conventional treatment strategies, psychiatric, psychological, or spiritual consultation may be of benefit and should be considered. Incorporate acceptable recommendations into the patient's care plan. If the consultant's recommendations are not carried out, document the reasons for this decision clearly in the patient' s record. The interdisciplinary team should monitor the patient's response to the course of treatment recommended by the pain consultant. In extreme cases of uncontrolled physical pain, palliative sedation should be considered. Palliative sedation for existential suffering is considered controversial and should be addressed with great caution and preferably in consultation with a palliative care specialist."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 13
Zitat (in Originalsprache): "Uni-dimensional assessments can be performed daily, or more frequently, if the information gained will help guide treatment."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 16
Zitat (in Originalsprache): "Progress notes should also be used for significant observations and exception reporting, especially for non-communicative residents."
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

APS_2005 APS (2005) Pain in Residential Aged Care Facilities – Management Strategies.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?

Seite: 16
Zitat (in Originalsprache): “Repeated assessments of pain are critical to effective pain management. It is important to evaluate and document changes in a resident’s pain intensity, mood and function including the effect of treatment over time.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: S7 (Table 6)
Zitat (in Originalsprache): “Adjust the pharmacotherapeutic regimen and monitoring plan.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Hadjistavropoulos et al._2010 Hadjistavropoulos, T., Fitzgerald, T.D., Marchildon, G.P. (2010). Practice guidelines for assessing pain in older persons with dementia residing in long-term care facilities.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 107
Zitat (in Originalsprache): “(…) monitor the efficacy of pain-management interventions.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: Hadjistavropoulos, T., Marchildon, G.P., Fine, P.G., Herr, K., Palley, H.A., Kaasalainen, S., Beland, F. (2009).Transforming long-term care pain management in North America: the polisclinical interface. Pain Med.; 10 (3): S. 506-520.

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 6-7
Zitat (in Originalsprache): TREATMENT PLAN DEVELOPMENT AND IMPLEMENTATION “A. Information collected from the Pain Assessment is to be used to formulate and implement a resident specific Pain Treatment Plan within the facility, or the resident shall be referred for treatment or consultation.” “(…) E. Pain Assessment findings shall be documented in the resident’s medical record. This shall include, but not be limited to, the date, pain rating, treatment plan, and resident response.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?

Seite: 46
Zitat (in Originalsprache): “Systematic and regular reassessment of pain should be established in order to identify the efficacy of the pain intervention activities chosen and to determine any need for revision in the pain management plan (Chibnall & Tait, 2001; Pasero et al., 1999a; VHA/DoD, 2002).”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Chibnall, J.T., Tait, R.C. (2001). Pain assessment in cognitively impaired and unimpaired older adults: a comparison of four scales. Pain; 92: S. 173–186. Pasero, C., Gordon, D.B., McCaffery, M., Ferrell, B.R. (1999a). Building institutional commitment to improving pain management. In McCaffery, M., Pasero, C. (ed.), Pain: Clinical Manual for Nursing Practice (2nd ed): S. 711-744. St. Louis, MO: Mosby. (V-b). VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, 1 (1). Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 46
Zitat (in Originalsprache): “Revise pain management plan if pain relief is not adequate. Consult with the patient’s physician, nursing staff, rehabilitation and the pharmacy department.”
Evidence-Grad und/oder Empfehlungsstärke: D
Referenzen: McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual (2nd ed.). St. Louis, MO: Mosby. (Vb). VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

Horgas et al._2008 Horgas A.L., Yoon S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T. editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 67
Zitat (in Originalsprache): “If pain is suspected, consider a time-limited trial of an appropriate type and dose of an analgesic agent. Thoroughly investigate behavior changes to rule out other causes. Use the PAINAD to evaluate the pain before and after administering the analgesic.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: siehe Frage 32

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite 12 (2007)
Zitat (in Originalsprache):

“Recommend changes in analgesics when inadequate pain relief is observed.”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 45 (2002)
Zitat (in Originalsprache): “Changes in pain patterns or the development of new pain should not be attributed to pre-existing causes, but instead should trigger diagnostic evaluation (AHCPR, 1994).”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services.
Anmerkung zur Aktualität der Referenzen /z. b alte Quell LL/Empfehlungen (bitte Jahrgang der ursprünglichen Empfehlung angeben):Quelle nicht gefunden
Ggf. weitere Bemerkungen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 45 (2002)
Zitat (in Originalsprache): “Pain should be reassessed at each new report of pain, with increased intensity of pain and when pain is not relieved by previously effective strategies (AHCPR, 1994). Changes in pain patterns or the development of new pain should not be attributed to pre-existing causes, but instead should trigger diagnostic evaluation (AHCPR, 1994).”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Agency for Health Care Policy and Research (AHCPR) (1994). Management of cancer pain. Clinical practice guideline; (9): Agency for Health Care Policy and Research, Public Health Services: U.S. Department of Health and Human Services.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 37: Welche Konsequenz sollte die Verlaufskontrolle von Schmerz für die Bewohner haben?
Seite: 48 (2002)
Zitat (in Originalsprache): “Advocate on behalf of the person for changes to the treatment plan if pain is not being relieved. The nurse will engage in discussion with the interdisciplinary health care team regarding identified need for change in the treatment plan. The nurse supports his/her rec ommendations with appropriate evidence, providing a clear rationale for the need for change (…).”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Lynch, E.P., Lazor, M.A., Gellis, J.E., Orav, J., Goldman, L., Marcantonio, E.R. (1998). The impact of postoperative pain on the development of postoperative delirium. Anesthesia & Analgesia; 86 (4): S. 781-785. (II-b).

Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?

AMDA_2009_2012 American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Seite: 6
Zitat (in Originalsprache): “Document ongoing pain assessment and the effectiveness of all treatments in every patient' s medical record.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Hadjistavropoulos et al._2007 Hadjistavropoulos, T., Herr, K. et al. (2007). “An interdisciplinary expert consensus statement on assessment of pain in older persons.” Clinical Journal of Pain; 23 (1): S. S1-S43.
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Seite: S3 (Table 2)
Zitat (in Originalsprache): “Documentation procedures that facilitate monitoring and communication are recommended.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

HCANJ _2006 Health Care Association of New Jersey (HCANJ) (2006). Pain management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ).
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Seite: 19-21
“Data Collection For Analysis, Outcome Evaluation and Performance Improvement Forms: • Pain Screen Form • Pain Assessment Form • Pain Treatment Form”
Zitat (in Originalsprache):
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Seite: 14
Zitat (in Originalsprache): **“ Document pain in a visible place that can be used by other health care providers.** This may be where vital signs are documented or on a separate pain flowsheet. Information important to document includes: date; time; pain intensity rating; quality (e.g., sharp, dull, burning etc.); location; onset and duration; comfort-function goal; analgesic information (e.g., drug, dose, route, frequency); other pain interventions; vital signs and side effects (APS, 2003; Arnstein, 2002; Faries et al., 1991; McCaffery & Pasero, 1999; O'Connor, 2003; VHA/DoD, 2002; Voigt et al., 1995).**—B “**
Evidence-Grad und/oder Empfehlungsstärke: B
Referenzen: APS American Pain Society (2003). Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (Fifth ed.). Glenview, Illinois: American Pain Society (APS). (V-b).

Arnstein, P. (2002). Optimizing perioperative pain management. AORN Journal; 76: S. 82-818. (V-b).
Faries, J.E., Mills, D.S., Goldsmith, K.W., Phillips, K.D., Orr, J. (1991). Systematic pain records and their impact on pain control. Cancer Nursing; 14: S. 306-313. (II-a).
McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual (2nd ed.). St. Louis, MO: Mosby. (Vb).
O'Connor, M. (2003). Pain management: improving documentation of assessment and intensity.Journal for Healthcare Quality; 25 (1): S. 17-22. (III-b).
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).
Voigt, L., Paice, J.A., Pouliot, J. (1995). Standardized pain flowsheet: Impact on patient-reported pain experiences after cardiovascular surgery. American Journal of Critical Care; 4: S. 308- 313. (II-a).

Herr et al._2006
Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.

Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?

Seite: 48-54

Zitat (in Originalsprache):

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen

Referenzen: nicht ausgewiesen

Ggf. weitere Bemerkungen
Die Verwendung der Nursing Interventions Classification (NIC) und der Nursing Outcomes Classification (NOC) werden nahe gelegt. Die Zitation der empfohlenen Items aus NIC und NOC ist nicht sinnvoll, da beide Klassifikationen in revidierten Fassungen vorliegen.

Horgas et al_2008
Horgas A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.

Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?

Seite: 4

Zitat (in Originalsprache): “Monitor medications closely to avoid over- or under-medication. Document treatment plan to maintain consistency across shifts and with other care providers.”

Evidence-Grad und/oder Empfehlungsstärke: Level VI

Referenzen:
American Geriatrics Society Panel on Persistent Pain in Older Persons (2002). Clinical practice guidelines: The management of persistent pain in older persons. JAGS; 50: S. S205-S224.

Horgas et al_2008
Horgas A.L., Yoon, S.L. (2008). Pain management. In: Capezuti, E., Zwicker, D., Mezey, M., Fulmer, T., editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company: S. 199-222.

Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Es gibt keine Aussagen dazu.

Seite: 4

Zitat (in Originalsprache):
“Follow-up assessment
l Monitor treatment effects within 1 hour of administration and at least every 4 hours.
l Evaluate patient for pain relief and side effects of treatment.

l Document patient's response to treatment effects. l Document treatment regimen in patient care plan to facilitate consistent implementation.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Seite: 6 (2007)
Zitat (in Originalsprache): “Document pain assessment regularly and routinely on standardized forms that are accessible to all clinicians involved in care.”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39. Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90. Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research; 35 (4): S. 58-71. Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861. van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609. van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491. Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007 Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.
Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?
Seite 6 (2007)
Zitat (in Originalsprache): “Teach individuals and families (as proxy recorders) to document pain assessment on the appropriate tools when care is provided. This will facilitate their contributions to the treatment plan and will promote continuity of effective pain management across all settings.”
Evidence-Grad und/oder Empfehlungsstärke: C
Referenzen: Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39. van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491. Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229. Royal College of Nursing (RCN) (1999). Clinical practice guidelines - The recognition and assessment of acute pain in children. Technical report. London: Royal College of Nursing.

Institute for Clinical Systems Improvement (ICSI) (2001). Health care guideline: Assessment and management of acute pain.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 38: Wie sollte die Verlaufserfassung dokumentiert werden?

Seite: 46

Zitat (in Originalsprache):
2002:
“Document on a standardized form that captures the person’s pain experience specific to the population and setting of care. Documentation tools will include:
(Grade of Recommendation = C)
_ Initial assessment, comprehensive assessment and re-assessment.
_ Monitoring tools that track efficacy of interventions (0-10 scale).”

2007
“Document on a standardized form that captures the person’s pain experience specific to the population and setting of care. Documentation tools will include:
■ Initial assessment, comprehensive assessment and re-assessment.
■ Monitoring tools that track efficacy of intervention (0-10 scale).
Grade of Recommendation = C „

Evidence-Grad und/oder Empfehlungsstärke: C

Referenzen:
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical Nursing, 13 (6b): S. 74-90.
Kaasalainen, S., Crook, J. (2003). A comparison of pain-assessment tools for use with elderly long-term-care residents. Canadian Journal of Nursing Research; 35 (4): S. 58-71.
Kleiber, C., Craft-Rosenberg, M., Harper, D.C. (2001). Parents as distraction coaches during IV insertion: A randomized study. Journal of Pain and Symptom Management; 22 (4): S. 851-861.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?

AMDA_2009_2012
American Medical Directors Association (AMDA) (2012). Pain management in the long-term care setting. Columbia (MD): American Medical Directors Association (AMDA); 48.

Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?

Seite: 35

Zitat (in Originalsprache):

"Resolving Conflicts and Challenges in Pain Management

Staff members and practitioners in the LTC setting commonly face challenges in pain management. Among those challenges are patient or family refusal of potentially beneficial treatments, pressures to prescribe certain medications or approaches and not others, and misconceptions that affect treatment choice. Family members may be fearful that increasing the amount or the scheduled dosing of opioid analgesics, as needed for pain management in some patients, may hasten the death of their loved one.

A commitment to patient comfort should be emphasized by the medical director and other members of the interdisciplinary team. Occasionally, family members may begin to discuss physician-assisted suicide when they become aware of the need to increase the amount of narcotic analgesic delivered or in response to other issues in pain management. Practitioners should use the discussion of pain management with patients and family members to address and review advance care planning and should reassure patients and their families that opioids are used to treat pain and other symptoms and are not prescribed in lethal doses.

Patients and families or health care proxies should be encouraged to discuss their preferences for pain management. A situation can often be resolved by recognizing the underlying message; for example, an apparent demand to give a patient a high dose of a high-risk medication may be a family's way of presenting its concern that pain be managed adequately. In such cases, simple explanations may suffice. Again, the use of handouts designed to educate patients and family members may be useful. Alternatively; refusal of an analgesic may not be absolute and may represent a desire to maintain lucidity rather than obtain complete pain relief. The practitioner is not obliged to accede to demands by a patient, family, or health care proxy for specific treatments that are inconsistent with his or her assessment of the patient' s best interests. Patients and families are generally not trained to identify underlying causes of symptoms, recognize alternative explanations for similar symptoms, or appreciate the risks and contraindications of treatments.

When patients, families, or health care proxies resist the use of potentially beneficial treatments, members of the interdisciplinary team should discuss the situation both among themselves and with the patient, family; or health care proxies and offer potentially useful alternatives, even if these may be less effective than the rejected approach. The medica1 director may be able to help to guide the interdisciplinary team in such situations. Educational opportunities and care refusals should be documented.

Some patients may continue to complain of chronic pain symptoms despite numerous efforts over many months or years to find appropriate relief. In some cases, consideration of more advanced methods such as a pain pump may be warranted. When no identifiable causes or significant relief can be found, it may be necessary to explain to the patient and family or health care proxy that all reasonable efforts have been tried and that it is not medically appropriate to continue to add more drugs, to change to medications that have more side effects or present higher risks to the patient, or to recommend procedures that are unlikely to be of benefit. It is also appropriate to consider consultation with a pain management specialist, neurologist, orthopedist, palliative care specialist or physiatrist for diagnostic and therapeutic suggestions. It may also be appropriate to consult a psychiatrist for an opinion about whether mood disorders, personality disorders, somatoform disorders, substance abuse or dependence disorders, or other psychiatric conditions may be presenting as or exacerbating pain symptoms. In some instances, seeking the assistance of the ombudsman may be appropriate."

Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

BPS & BGS_2007 The assessment of pain in older people: National Guidelines (2007) A joint publication produced by the Royal College of Physicians, the British Geriatrics Society and the BPS.
Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?
Seite: 11-12
Zitat (in Originalsprache): “Carers (formal and informal) can augment the detection of the presence of pain.”
Evidence-Grad und/oder Empfehlungsstärke: nicht ausgewiesen
Referenzen: nicht ausgewiesen

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?
Seite: 23
Zitat (in Originalsprache): **“Assess the older adult’s and family’s understanding and accurate use of the selected pain intensity tool.** Explain to the older adult that they must tell their nurses or physicians if they have pain that interferes with their accomplishing the identified functional goals (Ferrell et al., 1994; McDonald et al., 2001; Pasero, 2004a; Puntillo & Weiss, 1994; VHA/DoD, 2002; Ward & Gordon, 1994; Wilkie et al.,1995).**—B “**
Evidence-Grad und/oder Empfehlungsstärke: B
Referenzen: Ferrell, B.R., Ferrell, B.A., Ahn, C., Tran, K. (1994). Pain management for elderly patients withcancer at home. Cancer Supplement; 74 (7): S. 2139-2146. (II-a). McDonald, D.D., Freeland, M., Thomas, G., Moore, J. (2001). Testing a preoperative pain management intervention for elders. Research in Nursing & Health; 24 (5): S. 402-409. (II-a). Pasero, C. (2004a). Perineural local anesthetic infusion. American Journal of Nursing; 104 (7): S. 89- 93. (V-b). Puntillo, K., Weiss, S.J. (1994). Pain: Its mediators and associated morbidity in critically ill cardiovascular surgical patients. Nursing Research; 43 (1): S. 31-36. (III-a). VHA/DoD (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense.(IV-b). Ward, S.E., Gordon, D. (1994). Application of the American Pain Society quality assurance standards. Pain; 56: S. 299-306. (III-b) Wilkie, D.J., Williams, A.R., Grevstad, P., Mekwa, J. (1995). Coaching persons with lung cancer to report sensory pain: Literature review and pilot study findings. Cancer Nursing; 18 (1): S. 7-15. (II-a).

Herr et al._2006 Herr, K., Bjoro, K., Steffensmeier, J., Rakel, B. (2006). Acute pain management in older adults. Iowa City (IA). University of Iowa Gerontological Nursing Interventions Research Center, Research Translastion and Dissemination Core.
Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?
Seite: 23

Zitat (in Originalsprache):
"(…) Consult with the patient's physician, nursing staff, rehabilitation and the pharmacy department."

Evidence-Grad und/oder Empfehlungsstärke: D

Referenzen:
McCaffery, M., Pasero, C. (1999). Pain: Clinical Manual. 2nd ed. St. Louis, MO: Mosby. (Vb).
VHA/DoD. (2002). VHA/DoD Clinical practice guideline for the management of postoperative pain, Version 1.1. Washington, D.C.: Veterans Health Administration, Department of Defense. (IV-b).

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?

Seite: 47-48

Zitat (in Originalsprache):
2002
"15. Advocate on behalf of the person for changes to the treatment plan if pain is not being relieved. The nurse will engage in discussion with the interdisciplinary health care team regarding identified need for change in the treatment plan. The nurse supports his/her recommendations with appropriate evidence, providing a clear rationale for the need for change, including: (Grade of Recommendation = C)"
2007:

Evidence-Grad und/oder Empfehlungsstärke: C

Referenzen:
Alamo, M.M., Moral, R.R., de Torres, L. (2002). Evaluation of a patient-centred approach in generalized musculoskeletal chronic pain/fibromyalgia patients in primary care. Patient Education and Counseling; 48 (1): S. 23-31.
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical
Nursing, 13 (6b): S. 74-90.
Cavender, K., Goff, M.D., Hollon, E.C. & Guzzetta, C.E. (2004). Parents' positioning and distracting children during venipuncture: Effects on children's pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
Voepel-Lewis, T., Merkel, S., Tait, A.R., Trzcinka, A., Malviya, S. (2002). The reliability and validity of the Face, Legs, Activity, Cry, Consolability observational tool as a measure of pain in children with cognitive impairment. Anesthesia & Analgesia; 95 (5): S. 1224-1229.

RNAO_2002_2007
Registered Nurses Association of Ontario (RNAO) (2002 revised 2007). Assessment and management of pain. Toronto (ON). And supplement.

Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?

Seite: 47-48

Zitat (in Originalsprache): 2002
“14. Communicate to members of the interdisciplinary team pain assessment findings by describing parameters of pain obtained through the use of a structured assessment tool, the relief or lack of relief obtained from treatment methods, person’s goals for pain treatment and the effect of pain on the person. (Grade of Recommendation = C)”
2007:

Evidence-Grad und/oder Empfehlungsstärke:C

Referenzen:
Alamo, M.M., Moral, R.R., de Torres, L. (2002). Evaluation of a patient-centred approach in generalized musculoskeletal chronic pain/fibromyalgia patients in primary care. Patient Education and Counseling; 48 (1): S. 23-31.
Bird, J. (2003). Selection of pain measurement tools. Nursing Standard; 18 (13): S. 33-39.
Brown, D. (2004). A literature review exploring how healthcare professionals contribute to the assessment and control of postoperative pain in older people. Journal of Clinical
Nursing, 13 (6b): S. 74-90.
Cavender, K., Goff, M.D., Hollon, E.C. & Guzzetta, C.E. (2004). Parents’ positioning and distracting children during venipuncture: Effects on children’s pain, fear, and distress. Journal of Holistic Nursing; 22 (1): S. 32-56.
van Dijk, M., de Boer, J.B., Koot, H.M., Duivenvoorden, H.J., Passchier, J., Bouwmeester, N. et al. (2001). The association between physiological and behavioral pain measures in 0- to 3-year-old infants after major surgery. Journal of Pain and Symptom Management; 22 (1): S. 600-609.
van Dijk, M., Peters, J.W., Bouwmeester, N.J., Tibboel, D. (2002). Are postoperative pain instruments useful for specific groups of vulnerable infants? Clinics in Perinatology; 29 (3): S. 469-491.
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Frage 39: Welche Kommunikations- und Entscheidungswege (Schnittstellen) sind für die Verlaufserfassung notwendig?

Seite: 47-48

Zitat (in Originalsprache):
2002
“13. Validate with persons/care providers that the findings of the pain assessment (health care provider’s and person’s/care provider’s) reflect the individual’s experience of pain.
(Grade of Recommendation = C)”
2007:

Evidence-Grad und/oder Empfehlungsstärke:C

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