IDENTIFYING POTENTIAL SYMPTOMS IN NON-VERBAL INDIVIDUALS

Individuals that are non-verbal may not be able to communicate symptoms of pain or illness.

See below for strategies to utilize in order to determine how an individual is feeling.

Complete the Chronic Pain Scale for Nonverbal Adults with Intellectual Disabilities (CPS-NAID)

- Complete the CPS-NAID (see attached) twice per day. Morning and afternoon.
  1. Set and start timer for 5 minutes
  2. Observe the individual for 5 minutes and complete questions 1- 24
  3. Tally up scores and check whether scores are greater than the cut-off Score
- A score of 10 or greater means that there is a 94% chance that the person **has** pain. A score of 9 or lower means that there is an 87% chance that the person does **not** have pain.

An Increase In Behaviour

- Another indication that an individual may be feeling sick is if there is a sudden increase in a challenging behaviour that has been observed before. This increase can look differently depending on the person. Here are some ways The increase can :
- **Intensity:** The behaviour has increased in severity
- **Duration:** The behaviour is occurring for longer lengths of time
- **Frequency:** The behaviour is occurring more often

A New Behaviour

- A new behaviour may emerge when an individual is in pain or feeling unwell. The new behaviour is something that has not been previously observed and can vary in intensity, duration, and frequency (dependent on the individual).

A Change in Behaviour

- Change in typical behaviour (I.e., change in appetite, energy, sleep) might be an indication that the non-verbal individual is feeling ill.

Baseline Behaviours

My eating habits are:

My sleeping habits are:

A typical day for me is:

When I am happy I:

When I am sick I:

Chronic Pain Scale for Nonverbal Adults With Intellectual Disabilities (CPS-NAID)

Please indicate how often this person has shown the signs referred to in items 1-24 in the last 5 minutes.
Please circle a number for each item. If an item does not apply to this person (for example, this person cannot reach with his/her hands), then indicate "not applicable" for that item.

0 -	Not present at all during the observation period. (Note: If the item is not present because the person is not capable of performing that act, it should be scored as "NA").
1 -	Seen or heard rarely (hardly at all), but is present.
2 -	Seen or heard a number of times, but not continuous (not all the time).
3 -	Seen or heard often, almost continuous (almost all the time); anyone would easily notice this if they saw the person for a few moments during the observation time.
NA -	Not applicable. This person is not capable of performing this action.

	0 = Not at all	1 = Just a little	2 = Fairly Often	3 = Very Often	NA = Not Applicable
1.	Moaning, whining, whimpering (fairly soft)	0	1	2	3	NA
2.	Crying (moderately loud)	0	1	2	3	NA
3.	A specific sound or word for pain (e.g. A word, cry or type of laugh)	0	1	2	3	NA
4.	Not cooperating, irritable, unhappy	0	1	2	3	NA
5.	Less interaction with others, withdrawn	0	1	2	3	NA
6.	Seeking comfort of physical closeness	0	1	2	3	NA
7.	Being difficult to distract, not able to satisfy or pacify	0	1	2	3	NA
8.	A furrowed brow	0	1	2	3	NA
9.	A change in eyes, including: squinching of eyes opened wide, eyes frowning	0	1	2	3	NA
10.	Turning down of mouth, not smiling	0	1	2	3	NA
11.	Lips puckering up, tight, pouting or quivering	0	1	2	3	NA
12.	Clenching or grinding teeth, chewing or thrusting tongue out	0	1	2	3	NA
13.	Not moving, less active, quiet	0	1	2	3	NA
14.	Stiff, spastic, tense, rigid	0	1	2	3	NA
15.	Gesturing to or touching part of the body that hurts	0	1	2	3	NA
16.	Protecting, favouring or guarding part of body that hurts	0	1	2	3	NA
17.	Flinching or moving the body part away, being sensitive to touch	0	1	2	3	NA
18.	Moving the body in a specific way to show pain (e.g. Head back, arms down, curls up, etc.)	0	1	2	3	NA
19.	Shivering	0	1	2	3	NA
20.	Change in colour, pallor	0	1	2	3	NA
21.	Sweating, perspiring	0	1	2	3	NA
22.	Tears	0	1	2	3	NA
23.	Sharp intake of breath, gasping	0	1	2	3	NA
24.	Breath holding	0	1	2	3	NA
	Subtotals:					
1.	For each subtotal write the number of times each value was chosen	NA	1x___	2 x___	3x___	NA
2.	Multiply the value of each selection by how many times that value was chosen					Total:
3.	Add each subtotal to find the total score		=____	=____	=____	____

SCORING:

1. Add up the scores for each item to compute the Total Score. Items marked "NA" are scored as "0" (zero).
2. Check whether the score is greater than the cut-off score.

A score of 10 or greater means that there is a 94% chance that the person has pain.

A score of 9 or lower means that there is an 87% chance that the person does not have pain.

For more information see Suffin, Breau et al., (2006). Pilot study of the feasibility of the Non-Communicating Children's Pain Checklist-Revised for pain assessment in adults with intellectual disabilities. Journal of Pain Management, 1(1). CPS-NAID © 2006 Breau, Suffin, Solomon, Sandfield-Turner, Mullen.