Developing a Pain Assessment Tool for People with Dementia and Communication Difficulties

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Introduction And Background

• THE AIM of the project was to identify and implement a pain assessment tool sensitive to the cognitively impaired patient in acute care settings.

This Practice Development project examined and trialled observational pain assessment tools for people with dementia.

A group of clinicians identified lack of a formal pain assessment tool as a problem for the increasing number of older patients admitted to the hospital with cognitive impairment and dementia.

• Effective Communication is essential for obtaining pain relief (McDonald et al 2005).

• Cognitively impaired patients may not be able to articulate and convey the way they feel (Curvo et al 2007)

• Some older people are unable to describe and report their pain due to sensory and cognitive impairment making communication difficult (Help the Aged 2008).

Method

The method and approaches used were based on a participatory action research (PAR) methodology.

Changing pain assessment practice required accessibility and support from the medical and clinical team, therefore influential clinicians responsible for pain assessment practice participated in the decisions made relating to the project and formed a multi-professional steering group. PAR is a process using stages of planning, acting, observing, reflecting and re-planning (Glasson et al 2006).

Activity

1. An examination of the literature relating to observational pain assessment tools. Summary of literature examining some observational pain assessment tool

2. They were evaluated by staff on the wards

Evaluation of Pain Assessment Tools by Ward Staff

SCALE	COMMENTS	Decision to use in the trial
ABBEY Pain Scale. Abbey et al (2004)	Validated in Long-term care and relies on previous knowledge of patient. Easy to use. Recommended by the RCP & BPS (2007)	✓
Checklist of nonverbal pain indicators (CNPI) observation score (Feldt 2000)	Used on hip fracture patients (n=88). Not pain specific, no grading of pain. Scores on movement and on rest. Devised for use in acute care (trauma) Simple layout	✓
PAINAID Pain Assessment IN Advanced Dementia (Warden et al 2003)	Small sample size all male and white. Tested in nursing homes and specialist dementia care units. Complicated to use and misleading. Liked the layout of the tool. Simple format	✓
PADE Pain Assessment for the Dementing Elderly (Villaneuva et al 2003)	2 studies involving 25 and then 40 residents over 10 day period Long-term care and extended amount of time required. Lots of questions i.e. 23 and over 2 pages long	✗
PACSLAC Pain Assessment Checklist for Seniors With Limited Ability to Communicate (Fuchs-Lacelle and Hadjistavropolous 2004)	Devised in long-term care and relies on knowledge of Patients. Not validated. List of 60 items with yes no responses. No measure of degree of pain.	✗
MOBID Mobilization-Observation-Behaviour-Intensity-Dementia (Husebo, et al 2007).	Used in nursing homes and validated with just 26 patients. Suitable for long-term care, chronic pain and muscular skeletal pain. Identifies three pain behaviours List of 60 items with yes no responses. No measure of degree of pain. difficult to elicit an intensity score	✗

"Observing behaviour is an aspect of all pain assessment, but when patients are unable to communicate, observation of pain behaviours may be the only means of obtaining information" (Ruder 2010).

Assessment Tool	PAINAD	Abbey	CNPI
Mean Score (up to 10)	7.75	7.4	4.2
Comments	'A very good pain assessment tool, easy to use.' Remove the 'Cheyne stoke'	'like the documentation effective and justifies analgesia'	Not clear what the numerical scores should action….would need several sheets per day if patient on regular observations'. 'no clear guidance as when to action giving pain relief'

Conclusion

• The PAINAD and the Abbey scales were rated equally by clinicians.

• The CNPI assessment tool was devised for acute care but in practice and when compared to other tools it was not useful

• Some patient's relatives did describe pain problems to nursing staff that had not been identified by the assessment tools.

• The family or usual carer have not been included in previous pain assessment scales and it was felt by everyone involved in the project that this was an important factor.

An assessment tool combining The Abbey and PAINAD has been produced which includes information from someone who knows the individual well and has been named BPAT.

• A proof of concept study is currently underway at University Hospital South Manchester. BPAT has also been trialled and positively evaluated in other trauma units. Further validation studies are proposed.

BPAT

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BOLTON PAIN ASSESSMENT SCALE
For patients with communication problems

NAME OF PATIENT…… WARD ……

NAME/DESIGNATION OF PERSON COMPLETING SCORE:…… Date and Time ……

SCORE	ABSENT 0	MILD 1	MODERATE 2	SEVERE 3	SCORE
VOCALISATION	none	Occasional moan or groan	Low level speech with a negative or disapproving quality	Repeatedly crying out, loud moaning or crying	
FACIAL EXPRESSION e.g.	Smiling or relaxed	Looking tense,	Sad Frowning,	Grimacing and looks frightened	
CHANGE IN BODY LANGUAGE	None	Tense, fidgeting	Guarding part of the body,	Withdrawn, rigid, fists clenched. Knees pulled up	
BEHAVIOURAL CHANGE	None	Increased confusion	Refusing to eat, alterations in usual pattern	Pulling or pushing away, striking out	
PHYSIOLOGICAL CHANGE	Normal	Occasional laboured breath, increased heart rate	Hyperventilation, increased heart rate and BP	Change in pulse BP, respiratory rate and perspiring, flushed or pallor	
PHYSICAL CHANGES	None	Skin tears	Pressure ulcers, arthritis	Post surgery, trauma,	
				TOTAL SCORE:	
Comments by family or usual care givers					
Pain on movement/ physiotherapy					
SCALE	0-2 = NO PAIN	3-7 MILD PAIN	9-13 MODERATE PAIN	14+ SEVERE PAIN	

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