Assessing Pain using Observational Pain Assessment Tools

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A comparison of two observational pain assessment tools used in the care of patients with dementia
Pain defined:

is an unpleasant sensory and emotional experience that we associate with tissue damage.

(Merskey and Bogduk 1994)
As dementia progresses, the ability to verbally communicate becomes more impaired. In dementia where language is impaired, it is more difficult to know what the person is experiencing. We need to read the cues?
Methodology

• Purposive sample recruited
• Criteria for inclusion: had challenging behaviour which may be related to pain.
• Sample from statutory and private sector
Pain continues to be under treated in people with Dementia.

People with advanced Dementia are on a third of the analgesia of their peer group with similar health status.


Assessment is Key.

Wide variety of assessment tools available but a limited evidence base.
A high percentage of professionals found the cues in the Abbey Pain Scale helpful in identifying pain.

- Behavioural change: 88%
- Facial expressions: 90%
- Change in body language: 90%
- Physical changes: 87%
- Physiological change: 86%

(Abbey, 2007)
Why use Abbey?

NICE recommendations as good an evidence base as any. Quick and transparent. Easily used by all professionals. A common point of reference.
Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6.
Name of resident: .................................................................
Name and designation of person completing the scale: ..............................
Date: ....................... Time: ..................................................
Latest pain relief given was............................................at...........hrs.

Q1. Vocalisation
eg whimpering, groaning, crying
Absent 0  Mild 1  Moderate 2  Severe 3

Q2. Facial expression
eg looking tense, frowning, grimacing, looking frightened
Absent 0  Mild 1  Moderate 2  Severe 3

Q3. Change in body language
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0  Mild 1  Moderate 2  Severe 3

Q4. Behavioural Change
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0  Mild 1  Moderate 2  Severe 3

Q5. Physiological change
eg temperature, pulse or blood pressure outside normal limits,
perspiring, flushing or pallor
Absent 0  Mild 1  Moderate 2  Severe 3

Q6. Physical changes
eg skin tears, pressure areas, arthritis, contractures,
previous injuries
Absent 0  Mild 1  Moderate 2  Severe 3

Add scores for 1 - 6 and record here

Now tick the box that matches the Total Pain Score

<table>
<thead>
<tr>
<th></th>
<th>0 - 2</th>
<th>3 - 7</th>
<th>8 - 13</th>
<th>14 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>No pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Finally, tick the box which matches the type of pain

Chronic  Acute  Acute on Chronic
Abbey Pain Scale
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How to use scale: While observing the resident, score questions 1 to 6.

Name of resident: ..........................................................

Name and designation of person completing the scale: ..................................................

Date: ........................................... Time: ..........................................................

Latest pain relief given was........................................... at ........ hrs.

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   Absent 0  Mild 1  Moderate 2  Severe 3

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Q6. **Physical changes**
   eg skin tears, pressure areas, arthritis, contractures,
   previous injuries
   Absent 0  Mild 1  Moderate 2  Severe 3
Add scores for 1 - 6 and record here

Total Pain Score

Now tick the box that matches the Total Pain Score

0 - 2
No pain

3 - 7
Mild

8 - 13
Moderate

14 +
Severe

Finally, tick the box which matches the type of pain

Chronic
Acute
Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002
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# Pain Assessment IN Advanced Dementia (PAINAD)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breathing</strong></td>
<td>Normal</td>
<td>Occasional labored breathing.</td>
<td>Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations</td>
<td></td>
</tr>
<tr>
<td>Independent of vocalization</td>
<td></td>
<td>Short period of hyperventilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Negative Vocalization</strong></td>
<td>None</td>
<td>Occasional moan or groan. Low level speech with a negative or disapproving quality</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying</td>
<td></td>
</tr>
<tr>
<td><strong>Facial expression</strong></td>
<td>Smiling, or inexpressive</td>
<td>Sad. Frightened. Frown</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td><strong>Body Language</strong></td>
<td>Relaxed</td>
<td>Tense. Distressed pacing. Fidgeting</td>
<td>Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out</td>
<td></td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract or reassure</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**
Best practice guidelines

If a person with dementia has unexplained changes in behaviour and/or shows signs of distress, health and social care professionals should assess whether the person is in pain, using an observational pain assessment tool if helpful. However, the possibility of other causes should be considered.

NICE 1.10.2.1
Other evidence base
Using the tools in practice

2011 study involving a sample of 13 cognitively impaired clients with a diagnosis of dementia. Both Abbey and Painad tools were used to see if pain could be identified using them. In practice the tools identified pain in this client group.
current or previous conditions in sample group

- Arthritis (current)
- Osteoporosis (current)
- CA (previous)
- Falls (previous)
- Fractures (previous)
- Infections (previous)
- Dental (current)
- Contractures (current)
Frequency of Abbey Scores

The full scale is 0 to 18
Painad scores

- Painad score of 4
- Painad score of 5
- Painad score of 6
- Painad score of 7
- Painad score of 8

The full scale is 0 to 10
Methods of identification
Further findings

- Statutory sector homes did not use an observational tool to identify pain.

- Private sector provider did promote use of an observational tool to identify pain.

- However the private sector facility used in the sample did not use an observational tool to identify pain.

- Non-compliance to best practice guidelines evident
Further findings

Both tools were easy to use.

The Painad tool, identified psychosocial distress rather than pain in one sample.
Conclusions

Taking pain histories is an important method for gathering information about painful co-morbidities.

In the non-communicative cognitively impaired, observational pain assessment tools are the ‘Gold standard’ for identifying pain.

Staff in residential and nursing care facilities need to have more training in how to use these tools.

Regular re-assessment of residents is important for gathering and monitoring pain.
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Questions

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If you are a health or care worker...

Remember that pain assessment tools are available which can help you assess the person’s pain and manage their symptoms. It is important to assess pain both when the person is at rest and during activity, such as doing everyday tasks.

Examples of these pain assessment tools include: PAINAD, Abbey and Doloplus. Links to more information are provided at www.ncpc.org.uk/dementia.