Development 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 The 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, 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

<table>
<thead>
<tr>
<th>SC:</th>
<th>COMMENTS</th>
</tr>
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<tbody>
<tr>
<td>PADE Pain Assessment for the Dementing Elderly (Warden et al 2003)</td>
<td>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</td>
</tr>
<tr>
<td>PACSLAC Pain Assessment Checklist for Seniors With Limited Ability to Communicate (Fuchs-Lacelle and Hadjistavropoulos 2004)</td>
<td>Used in nursing homes and validated with just 26 patients. Suitable for long-term care, chronic pain and musculoskeletal pain. Identifies three pain behaviours: List of 60 items with yes or no responses. No measure of degree of pain</td>
</tr>
<tr>
<td>MORB Mobilization-Observation Behaviour-Intensity-Dementia (Huskens et al 2007)</td>
<td>Used in nursing homes and validated with just 26 patients. Suitable for long-term care, chronic pain and musculoskeletal pain. Identifies three pain behaviours: List of 60 items with yes or no responses. No measure of degree of pain. Difficult to elicit an intensity score</td>
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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

BOLTON PAIN ASSESSMENT SCALE

For patients with communication problems

NAME OF PATIENT: ____________________________  Date and Time: __________

NAME/DESIGNATION OF PERSON COMPLETING SCORE: ____________________________

SCORE| ABSENT | 0 | MILD 1 | MODERATE 2 | SEVERE 3 | TOTAL: ____________________________
---|---|---|---|---|---|---
VOCAILISATION | None | Occasional moan or groan | Low level speech with a negative or depressing quality | Sighing, crying, moaning, or crying |
FACIAL EXPRESSION | None | Rolling, looking tense, or restless | Relaxed or frowning | Grimacing and looking frightened |
CHANGE IN BODY LANGUAGE | None | Tense, flopping, or guarding part of the body | Relaxed or resting | Withdrawn, rigid, frown, or clenched hands, knees pulled up |
BEHAVIOURAL CHANGE | None | Increased confusion or restlessness | Refusing to eat, or alterations in usual pattern | Walking, pulling or pushing away, or striking out |
PHYSIOLOGICAL CHANGE | Normal | Occasional laboured breath, or increased heart rate | Hyperventilation, or increased heart rate and ECG | Change in pulse, BP, respiration rate, or perspiring, flushed, or sweating |
PHYSICAL CHANGES | None | Skin tears | Pressure ulcers, arthritis | Post surgery, trauma, |

TOTAL SCORE: ____________________________

References


“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).

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