Dementia Friends

Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Pain Assessment Tool for People with Dementia or Communication Difficulties

In-Patient Pain Team July 2015

Purpose

- This pain tool is to aid the correct assessment of pain in patients with dementia and or communication difficulties.

When to use

- On admission to establish a base-line score
- 12 hourly or more frequently if the pain score is 2 / 3 or if the patient is displaying behavioural changes
- Reassess pain following intervention

Instructions for use

- Establish with the patient / or main carer the patients 'normal behaviour' and document in notes
- Assess the patient at rest and on movement completing each section of the pain tool
- Add all scores together to achieve a 'total score'
- Using the conversion table establish if the pain score is 0, 1, 2 or 3
- Document this score on the patients physiological observation chart
- HCA's should report a pain score of 2 or 3 to the trained nurse

Analgesic guidance

- Is the person on pain medication Y / N
- If answer is **No** then commence step wise approach to analgesia
- For moderate to severe pain ensure Morphine Protocol is prescribed PRN
- Pain should be assessed each shift – more frequently if pain is moderate or severe

CONSIDER NON-DRUG OPTIONS TO EASE PAIN AND PROMOTE COMFORT

STEP 1 – mild pain

Non-Opioid +/- adjuvant analgesia

eg Paracetamol +/- NSAIDS

Regular paracetamol – consider soluble

Regular NSAID (Ibuprofen) – consider gel or cream

STEP 2 – moderate pain

Non-Opioid +/- adjuvant analgesia

e.g. Codeine + STEP 1

Consider soluble Co-Codamol

Consider anti-emetics

Opiates cause constipation – prescribe regular laxatives

STEP 3 – severe pain

Strong Opioid +/- Adjuvant analgesia

e.g. Morphine / BuTrans Patch + STEP 1

Use with caution if patient has renal impairment

Prescribe Oramorph PRN

Prescribe regular laxatives

Use anti-emetics if required

Prescribing Considerations

BuTrans 7 day Patch – Start with a 5mcg/hr patch, increase after 7 days if required. Monitor for side effects e.g. sedation, nausea, constipation and treat proactively. Increased risk of falls at days 2-3 following initial patch or increased patch.

Oral Morphine – Long acting morphine e.g. MST / Zomorph (or equivalent opioid) should be prescribed twice daily at 12 hourly intervals. Short acting Morphine should be prescribed PRN for breakthrough pain. To help with procedural or functional pain give 30 minutes prior to procedure to ensure it has time to work.

For patients on regular strong opiates PRN morphine should be prescribed at one sixth of total daily opiate dose.

Pain assessment criteria				
	None 0	**Mild 1**	**Moderate 2**	**Severe 3**
Facial Expression	Smiling, relaxed Happy, patients normal facial expressions	Looks tense	Frowning, sad, fearful	Grimacing, teeth clenched, tearful, distorted expressions
Vocalisation	Patients normal vocalisation	Occasional moaning and groaning	Frequent moans and groans	Constant moaning and groaning, crying, shouting out, wailing
Body Language	Patients normal body language	Fidgeting, tense, restless	Holding or guarding the body part, agitated, rocking	Rigid, withdrawn, non-compliant, teeth clenched, fists clenched, knees pulled up
Physiological Self	Patients normal physiological self	Occasional increased respiration	Increase in BP, pulse and respiration	Increase in BP, pulse, respirations and temperature, sweating, flushed or cold and clammy
Behaviour	Patients normal behaviour pattern	Change in behaviour /mental state	Reluctant to eat, altered sleep pattern, worsening behaviour	Refuses to eat, will not tolerate touch, pushing away, hitting out, aggressive

Adapted from

- The 'Abbey Pain Tool' The British Pain Society (2007) CONCISE GUIDANCE TO GOOD PRACTICE A series of evidence-based guidelines for clinical management NUMBER 8 **The assessment of pain in older people** NATIONAL GUIDELINES: p13
- Warden, V, Hurley AC, Volicer, V. (2003). **Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale.** J Am Med Dir Assoc, 4:9-15. Developed at the New England Geriatric Research Education & Clinical Center, Bedford VAMC, MA.

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Total Score																																	
Initials																																	

CONVERT TOTAL SCORE USING SCALE BELOW

0 = **0** No Pain | 2-7 = **1** Mild Pain | 8-13 = **2** Moderate pain | 14 + = **3** Severe Pain

Document score on Physiological Observation Chart