Assessment of Pain in Older People: UK National Guidelines

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Hello

- Stand up

- Education
- Pain services
- Care / Nursing Homes
- Community care
- Private sector
- NHS acute care

Summary of National Guideline (2018)

- Assessment of pain in older people is a complex process
- Multi-Professional approach is essential
- Communication issues
- Self –report is most accurate
- Recommend PAINAD and Doloplus 2
- Education of all staff important – ongoing
- Need for more research – collaborative role of the MDT in all care settings

Areas to be examined

- Assessment of pain in older people is a complex process
- Communication issues
- Self -report
- Recommend PAINAD and Doloplus 2

Burden of pain

- Pain is commonly experienced by older people
- 75% MSK pain

- Interferes with activities – mainly walking, general activities, mood and enjoyment of life
- 48.1% medication (OTC mainly)
- 48.1% inactivity to relieve pain (Brown et al 2011)

Pain Management Process

- Assessment
- Intervention
- Evaluation and adjustment

Assessment is key to the management of pain

- **Assessment is a conversation, verbal & non-verbal with the patient and those who know them**
- Self – report considered most accurate
- Always attempt
- Responsibility of the Health Care Professional to consistently and regularly assess pain

SITE can the patient localise it with a finger or is it more diffuse? which area of the abdomen is affected?

ONSET when did it first start? did it come on suddenly or over time?

Has the patient ever had this type of pain before?

CHARACTER stabbing? aching? burning? Try to get the patient to describe in their own words exactly how it feels.

RADIATION does the pain move anywhere else?

ASSOCIATED SYMPTOMS bowel symptoms? urinary symptoms? any relation to menstrual period? date of last menstrual period?

TIME COURSE has the pain become worse/better/stayed the same over time?

EXACERBATING(and relieving) FACTORS movement? pressing on the area? eating? passing stool/urine? medicines tried?

SEVERITY rate the pain on a scale of 1 – 10 (1 being very slight pain, 10 being the worst pain.)

Measure Pain –Intensity

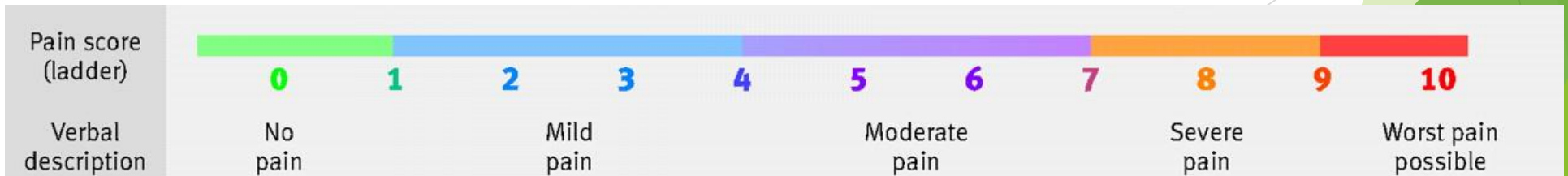
Recommended Pain intensity scales:

- Valid and reliable

- VAS -Visual Analogue Scale
- NRS (0-10) Numerical rating Scale
- VRS Verbal rating Scale (e.g. mild, moderate, severe)

- Documentation:

Score – NEWS, Care plan, notes – record



Chronic pain assessment

BPI (Brief Pain Inventory)

- 32 items
- Assesses pain intensity interference with functional activities
- Evaluation of treatment

McGill pain questionnaire

- 22 items
- Sensory/ descriptive
- Affective (makes your feel)
- Evaluative

Screening questions

- ACT-UP

- **Activities** –pain affects your life. E.g. sleep, appetite
- **Coping** – how do you cope with pain?
- **Think** – do you think your pain will ever get better
- **Upset** – feeling worried anxious/ depressed
- **People** – how do people respond to your pain

Assessment of Pain in older people

- Other health related problems compete for Health Care Professionals attention.

- Discount pain – accepted as part of ageing.

- Fear of drugs used,
  - side effects,
  - addiction etc.

Importance of wording

- Use appropriate words to elicit appropriate responses

- Many older people deny ‘pain’
  - Sore
  - Aching
  - Discomfort

  Do you hurt anywhere?

What is stopping you from doing……. ?

Assessment with older people

Communication

- ***Need time*** to consider question

Take into account:

- Hearing and understanding
- Memory.
- Cognitive impairment.
- Acute confusion (delirium).
- Dementia.

Pain Assessment and Cognitive Impairment

- **Self-report of pain should always be attempted &**

found to be suitable for many people:

- 68% with moderate to severe impairment (n = 59).

Attempt initially and adopt wording if necessary (instructions up to 3 times)

(Closs et al. 2004)

- 60% to 70% mild to moderate cognitive impairment Verbal Descriptor Scale can be used

(Kaasalainen & Crook 2004)

- Moderate dementia 60% NRS and 90% VDS (Lukas et al 2013)

Direct correlation between impaired cognition and poor pain management.

The recognition of pain in people with dementia is complex and challenging

What do we do when communication is an issue?

- *Observe behaviour*

- *Consider other factors*

Behaviours associated with pain (AGS 2002)

1. **Vocalisation**

   Shout

2. **Facial grimace**
3. **Body language**

   Rubbing, guarding

4. **Changes in behaviour**

aggression, resists movement

5. **Physiological change**

   Increase HR, BP, sweating

6. **Physical changes**

   Skin damage, fractures,

Recognition of pain

Simple and practical method of pain assessment still required

Corbett et al (2014)

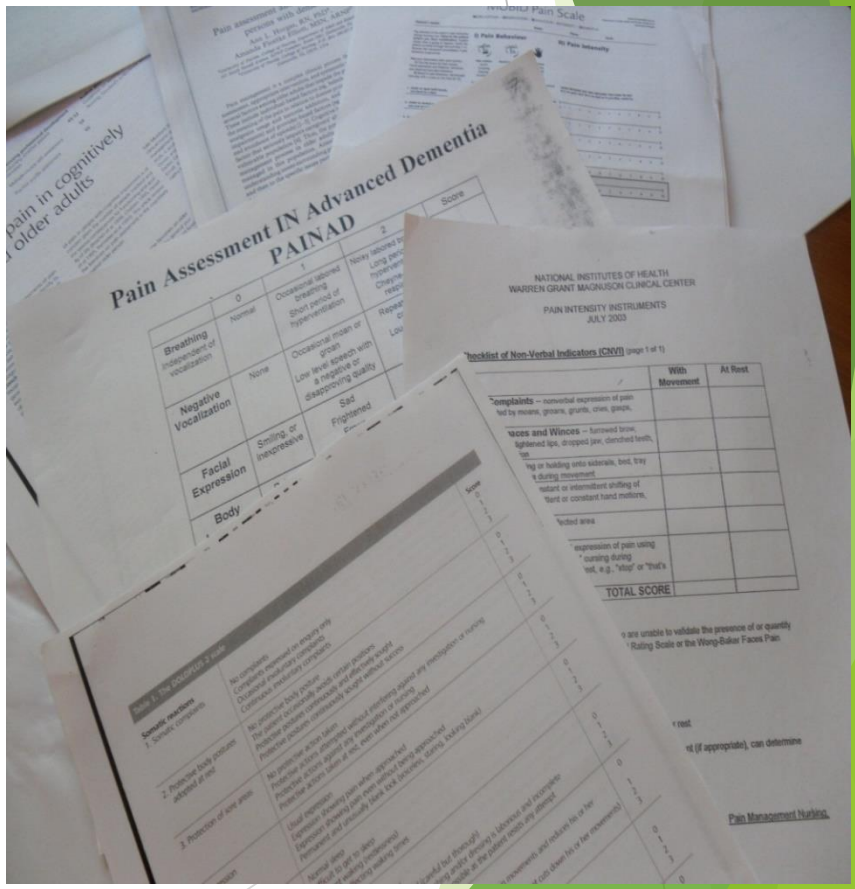
Consistent use of an appropriate pain assessment tool

Bray et al (2015)

Development of Observational Pain Tools (OPT)

Content of tools:

- Based on review of literature
- Involvement of ‘experts’
- Content and format varies
- Number of behaviours range from 6 to 61
- Scores range from 0 to 61 (some no scores produced)



Problems with behavioural assessment

- 158 indicators of pain Identified by 109 nurses

(Zwakhalen et al 2004)

- **No behaviour is unique to pain**
- Behaviour is unique to individuals
- Do carers pick up on behaviour?
- Suggestion - Need to ‘know the person’.
- Other reasons for distress
  - Fear and anxiety, anger and frustration
  - Distress from environment, others, change
  - Low mood, boredom, hallucinations

ASSESSMENT TOOL	AREA OF PRACTICE	NUMBER OF ITEMS	SCORE
The Abbey Scale	Long Term Care (LTC)	18	0-2 none 3-7 mild 8-13 moderate 14+ severe
CNPI (Checklist of Non Verbal Pain Indicators)	Acute Care LTC	12	0-12
Doloplus- 2	Hospitals Communication disorder Dementia	10	0-30
PACSLAC (Pain Assessment Scale for Seniors with Severe Dementia)	LTC	61	0-61
PAINAD (Pain Assessment in Advanced Dementia)	LTC	10	0-3 mild 4-6 moderate 7-10 severe
PADE (Pain Assessment in Dementing Elderly)	LTC	24	No
BPAT (Bolton Pain Assessment Tool)	Acute Care	18	0-2 none 3-7 mild 8-13 moderate 14+ severe

Reviews of OPT

- Number of published reviews
- Conclude not used in everyday practice
- Questions of R & V

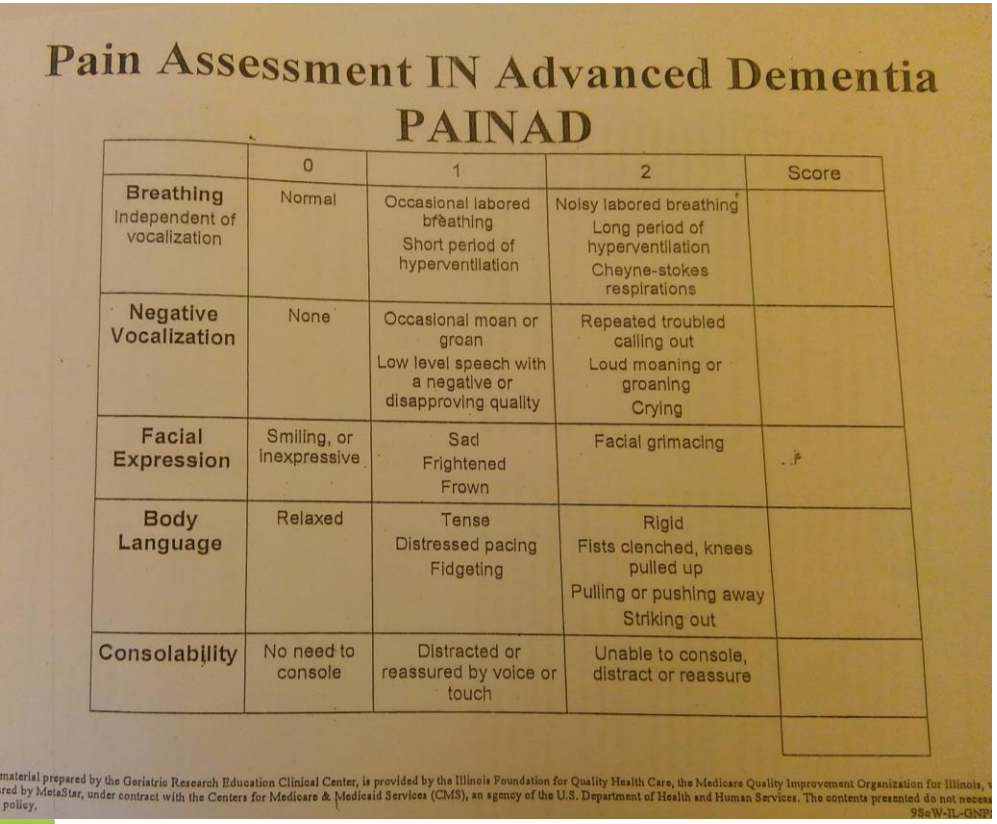
- Need for further testing of OPT
- Range of setting

Observational Study

- Nurses tended *not* to use pain assessment tools,
- Distrusted the scores obtained and
- Preferred to use their own experience to assess pain.

Dowding et al (2015)

PAINAD



Pain Assessment IN Advanced Dementia

PAINAD

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

material prepared by the Geriatric Research Education Clinical Center, is provided by the Illinois Foundation for Quality Health Care, the Medicare Quality Improvement Organization for Illinois, red by MetaStar, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not neces policy.

95eW-IL-GNP

- Based on FLACC and DS-DAT
- Initially tested on 19 white men in USA **Advanced dementia** – long-term care
- Simple and easy to use
- Detects pain – false positive
- Further testing has been undertaken in acute care

Doloplus 2

French – based on scale for young children

10 types of behaviour

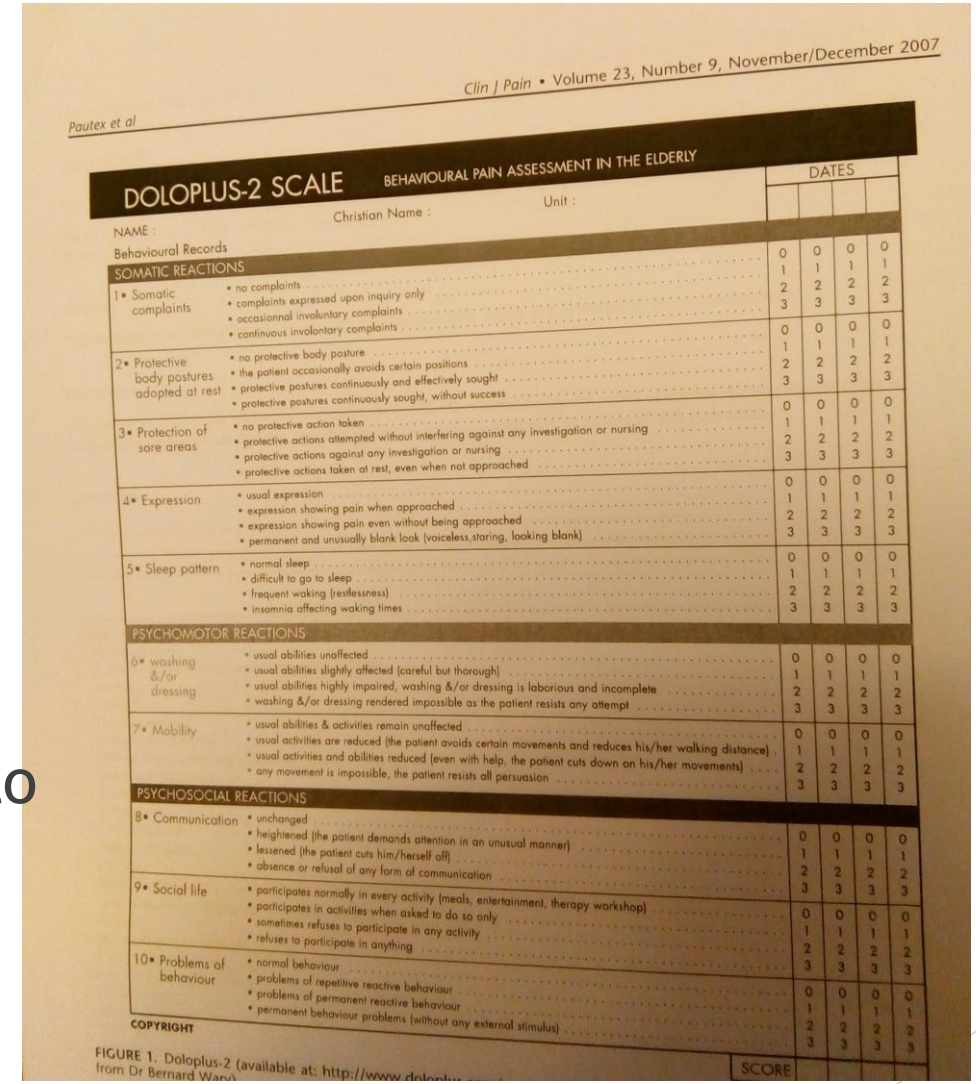
3 subscales

R&V – evidenced – compared to VAS

Translated into different languages

Requires more training

Not popular in UK



Pautex et al

Clin J Pain • Volume 23, Number 9, November/December 2007

DOLOPLUS-2 SCALE BEHAVIOURAL PAIN ASSESSMENT IN THE ELDERLY

NAME : Christian Name : Unit : DATES

Behavioural Records

SOMATIC REACTIONS					
1• Somatic complaints	• no complaints • complaints expressed upon inquiry only • occasionnal involuntary complaints • continuous involontary complaints	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
2• Protective body postures adopted at rest	• no protective body posture • the patient occasionally avoids certain positions • protective postures continuously and effectively sought • protective postures continuously sought, without success	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
3• Protection of sore areas	• no protective action taken • protective actions attempted without interfering against any investigation or nursing • protective actions against any investigation or nursing • protective actions taken at rest, even when not approached	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
4• Expression	• usual expression • expression showing pain when approached • expression showing pain even without being approached • permanent and unusually blank look (voiceless,staring, looking blank)	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
5• Sleep pattern	• normal sleep • difficult to go to sleep • frequent waking (restlessness) • insomnia affecting waking times	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
PSYCHOMOTOR REACTIONS					
6• washing &/or dressing	• usual abilities unaffected • usual abilities slightly affected (careful but thorough) • usual abilities highly impaired, washing &/or dressing is laborious and incomplete • washing &/or dressing rendered impossible as the patient resists any attempt	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
7• Mobility	• usual abilities & activities remain unaffected • usual activities are reduced (the patient avoids certain movements and reduces his/her walking distance) • usual activities and abilities reduced (even with help, the patient cuts down on his/her movements) • any movement is impossible, the patient resists all persuasion	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
PSYCHOSOCIAL REACTIONS					
8• Communication	• unchanged • heightened (the patient demands attention in an unusual manner) • lessened (the patient cuts him/herself off) • absence or refusal of any form of communication	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
9• Social life	• participates normally in every activity (meals, entertainment, therapy workshop) • participates in activities when asked to do so only • sometimes refuses to participate in any activity • refuses to participate in anything	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3
10• Problems of behaviour	• normal behaviour • problems of repetitive reactive behaviour • problems of permanent reactive behaviour • permanent behaviour problems (without any external stimulus)	0 1 2 3	0 1 2 3	0 1 2 3	0 1 2 3

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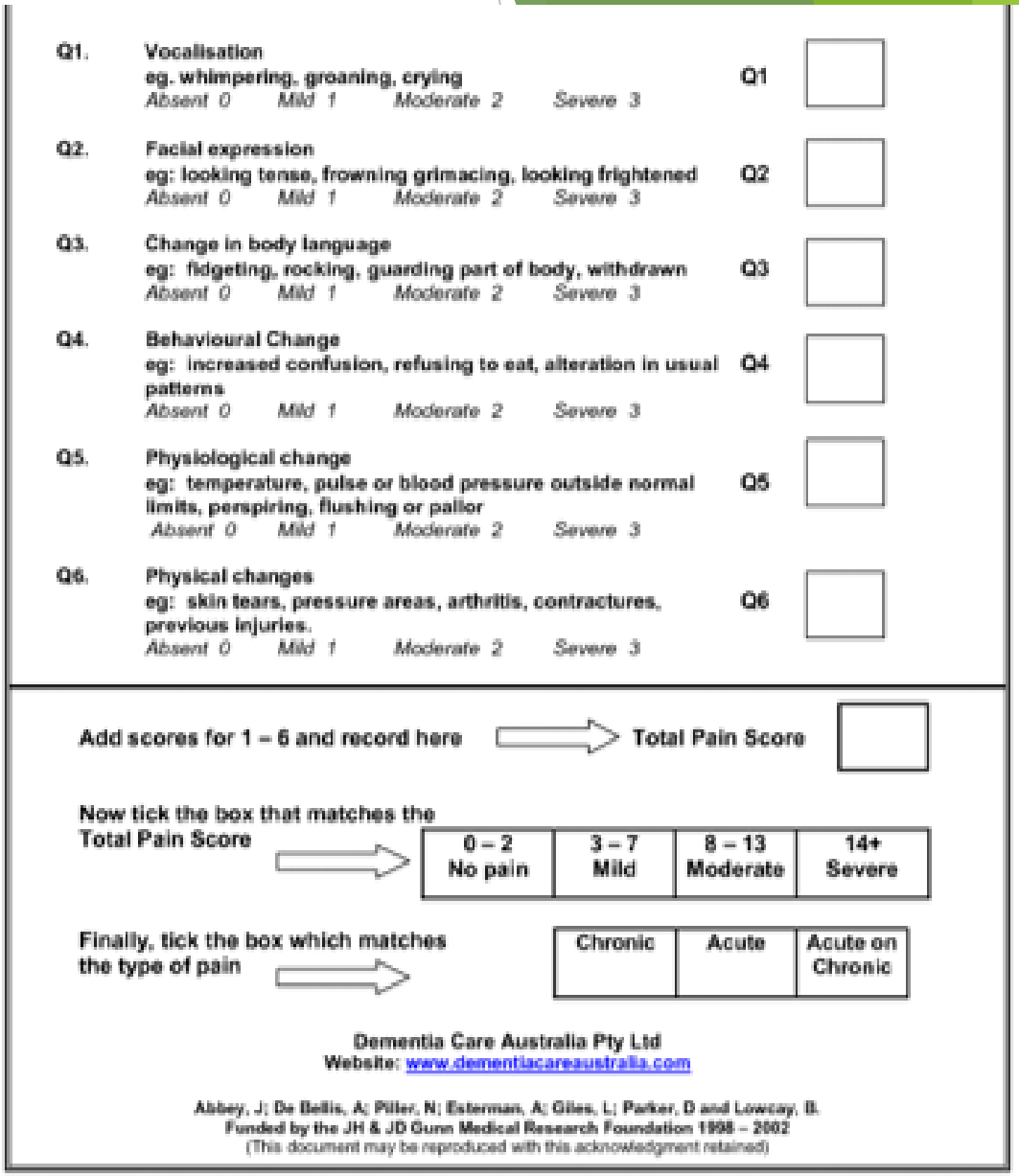
FIGURE 1. Doloplus-2 (available at: http://www.doloplus... from Dr Bernard Wary)

SCORE

Abbey Scale

- Tested in nursing homes in Australia
- Senior nurses confirmed the pain.
- Recommended for use in 2007
- Widely used in UK
- No further research
- Subjective



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

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

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

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

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

Q6. Physical changes
eg: skin tears, pressure areas, arthritis, contractures, previous injuries. — Q6
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

Dementia Care Australia Pty Ltd
Website: www.dementiacareaustralia.com

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
(This document may be reproduced with this acknowledgment retained)

BPAT Bolton Pain Assessment Tool

- Practice development project
- Tested three pain assessment tools in practice
- Issues with each
- Identified pain
- Need to involve family / carers identified
- Combined Abbey and PAINAD
- Tested in practice as a proof of concept
- Trauma units across UK
- Positive feedback:
- Quick &Easy to use
- Not always involve family
- One hospital – pain behaviours added to ‘this is me’
- Needs more research (V&R)

Bolton Pain Assessment Tool (For patients with communication difficulties i.e. Dementia, Stroke, Learning Disability, Acute confusion)					Date Time		
Score	No Pain 0	Mild 1	Moderate 2	Severe 3			
Vocalisation	None	E.g. Occasional groan	E.g. Low level speech with a negative or disapproving quality, whimpering	E.g. Repeatedly crying out loud, groaning, crying			
Facial Expression	E.g. Smiling, relaxed	E.g. Looking tense	E.g. Grimacing, frowning, looking tense	E.g. Grimacing and looks frightened			
Change to body language	None	E.g. Tense, fidgeting	E.g. Guarding part of the body	E.g. Withdrawn, rigid, fists clenched, knees pulled up			
Behavioural change	None	E.g. Increased confusion	E.g. Lack of appetite, alterations in usual pattern	E.g. Pulling or pushing away, striking out			
Physiological change	Normal	E.g. Sighing, increased heart rate	E.g. Hyperventilation, increased heart rate, BP, respiratory rate	E.g. Increased heart rate, BP, respiratory rate, perspiring, flushed or pallor			
Physical changes	None	E.g. Skin tears, bruising, grazes	E.g. Surgical wound, arthritis	E.g. Acute trauma, post-surgery < day 4			
Patient Name: Unit No:		Ask family or usual care giver about normal behaviours.		Total score 0 - 2 = no pain 3 - 8 = mild pain 9 - 14 = moderate 14+ = severe pain			

Holistic Assessment

Reflect on your practice

- Intuition may play a part in recognising pain
- Familiarity with the person or knowing the person important
- Suggested that pain relief for people with dementia may be improved if pain assessed with family informal caregivers
- Information about the person with dementia's history and preferences.
- Familiar with individual, history, idiosyncratic expressions and needs

(Buffam and Haberfelde 2007, McAucliff et al 2012, Schofield 2008, Herr 2010, Karlsson et al 2013).

Conclusion

- Assessment of pain in older people is a complex process
- Communication - major factor
- Self –report should always be attempted
- OPT limited use
- Guideline - Recommend PAINAD and Doloplus 2
- BPAT described as having potential
- Part of an holistic assessment
- Involve individual’s familiar with person

See pain more clearly

- https://www.youtube.com/watch?v=9ONjQ7_ZvZA

Thank You For Your Attention

Any Questions?