Pain Assessment in Persons with Dementia

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Funding Sources

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Outline

- Pain Undertreatment in Dementia
- Using Scales
- Self-Report Scales
- The PACSLAC and the PACSLAC-II
- Practical Recommendations for Pain Assessment

Behavioural Disturbance and Geriatric Pain

- A clear relationship between pain and behavioural disturbance has been demonstrated in people with severe dementia
- Pain can lead to delirium

Cipher, Clifford, & Roper (2006)

Pain Treatment in People with Dementia

- People with dementia are less likely to be treated for their pain than people who have the same painful conditions but no dementia
- People with dementia tend to be more expressive of their pain than people without dementia

Behavioural Disturbance Due to Pain Can be Misattributed

- Frequent, possibly inappropriate use of psychotropics and underutilization of analgesics
- Patients with painful conditions and dementia are more likely to be treated with psychotropics rather than analgesics (Balfour & O'Rourke, 2003)
- In dementia populations, psychotropics hasten death (e.g., risk of stroke and falls) (Woolcott et al., 2009)

Why Use Scales?

- Communication with other professionals
- Monitoring over time
- Evaluate effectiveness of interventions

Numeric and Verbal Rating Scales

- 0-10 scale

- “No Pain”, “Little Pain”, “Pain as bad as it can be” etc

Gagliese et al., (2005)

0	1	2	3	4	5	6
No Pain	Slight Pain	Mild Pain	M…e	Severe Pain	Extreme Pain	Pain as bad as it could be

Gagliese et al., (2005)

Rule of Thumb

- Patients with MMSE scores of 18 or higher can typically self-report pain
- Patients with MMSE scores of 13 or lower have considerable difficulties with the self-report of pain

Summary: Self-Report Scales

- Always attempt self-report
- Verbal Rating Scales (mild, moderate, severe)
- 0-10 scales
- Suitable for a large portion of patients with mild-moderate dementia

The PACSLAC

Facial Expressions	Present		Activity/Body Movement	Present		Social/Personality/Mood	Present
Grimacing			Pacing			Physical aggression	
Sad Look			Wandering			Verbal aggression	
Tighter face			Trying to leave			Not wanting to be touched	
Dirty look			Refusing to move			Not allowing people near	
Change in eyes			Thrashing			Angry/Mad	
Frowning			Decreased activity			Throwing things	
Pain expression			Refusing medications			Increased confusion	
Grim face			Moving slow			Anxious	
Clenching teeth			Impulsive Behaviour			Upset	
Wincing			Uncooperative/Resistant to care			Agitated	
Opening mouth			Guarding sore area			Cranky/Irritable	
Creasing forehead			Touching/holding sore area			Frustrated	
Screwing up nose			Limping			**Other***	
Activity/Body Movement			Clenched fist			Pale Face	
Fidgeting			Going into foetal position			Flushed, red face	
Pulling Away			Stiff/Rigid			Teary eyed	
Flinching						Sweating	
Restless						Shaking/Trembling	

Fuchs-Lacelle & Hadjistavropoulos, (2004)

The PACSLAC

Others continued	Present			
Cold & clammy			Sub-scale Scores:	
Changes in sleep (please circle): Decreased sleep or Increased sleep during day			Facial Expressions	
			Activity/Body Movement	
Changes in Appetite (please circle): Decreased appetite or Increased appetite				
			Social/Personality Mood	
Screaming/Yelling			Other	
Calling out (i.e. for help)				
Crying			Total Checklist Score	
A specific sound or vocalisation for pain ‘ow’, ouch’				
Moaning and groaning				
Mumbling				
Grunting				

The PACSLAC-II

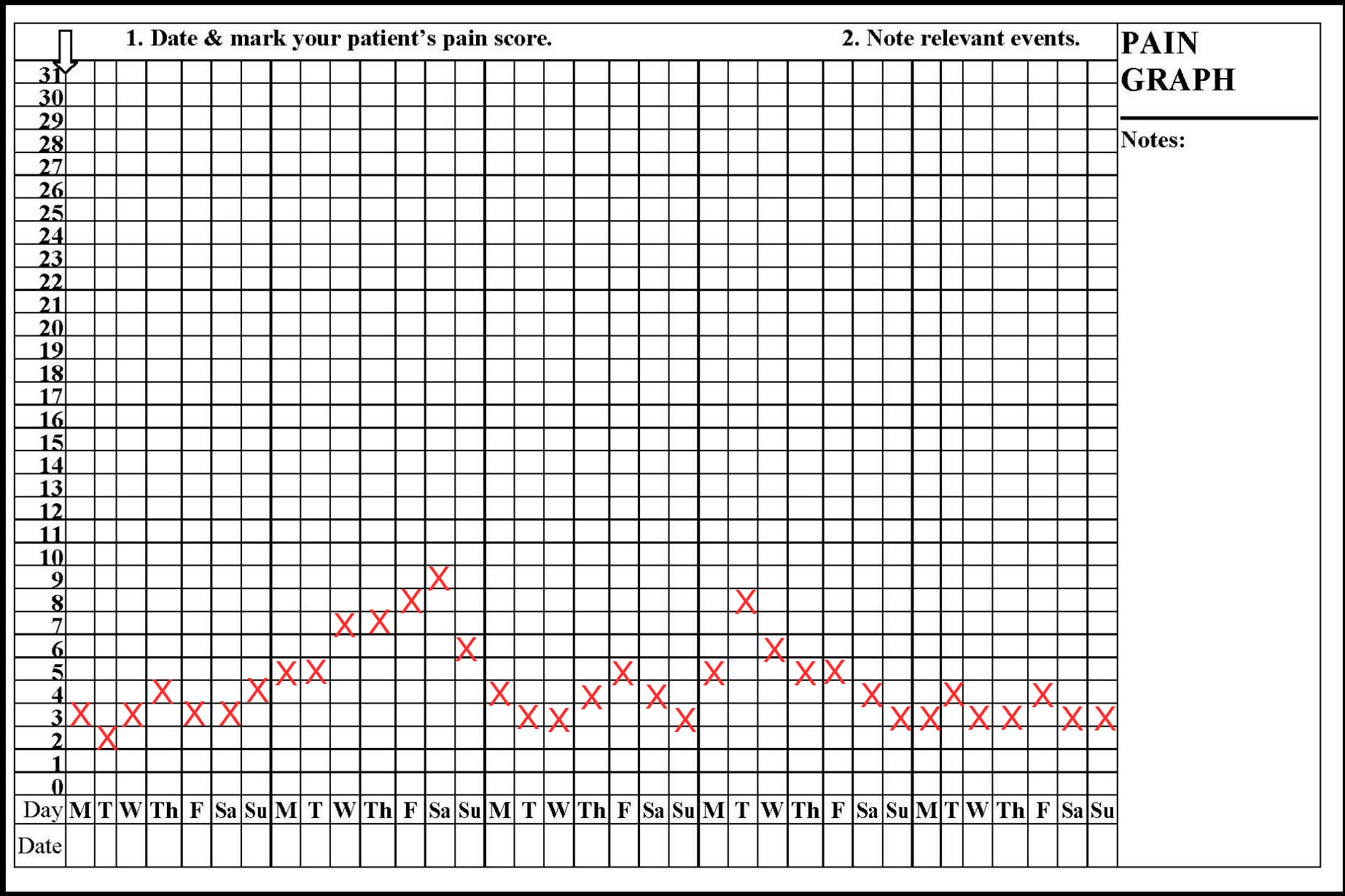
Pain Assessment Checklist for Seniors with Limited Ability to Communicate-II (PACSLAC-II)

Date of Assessment: _____ Time: _____	Check if present
Facial Expressions	
1. Grimacing	
2. Tighter face	
3. Pain expression	
4. Increased eye movement	
5. Wincing	
6. Opening mouth	
7. Creasing forehead	
8. Lowered eyebrows or frowning	
9. Raised cheeks, narrowing of the eyes or squinting	
10. Wrinkled nose and raised upper lip	
11. Eyes closing	
Verbalizations and Vocalizations	
12. Crying	
13. A specific sound for pain (e.g., 'ow', 'ouch')	
14. Moaning and groaning	
15. Grunting	
16. Gasping or breathing loudly	
Body Movements	
17. Flinching or pulling away	
18. Thrashing	
19. Refusing to move	
20. Moving slow	
21. Guarding sore area	
22. Rubbing or holding sore area	
23. Limping	
24. Clenched fist	
25. Going into foetal position	
26. Stiff or rigid	
27. Shaking or trembling	
Changes in Interpersonal Interactions	
28. Not wanting to be touched	
29. Not allowing people near	
Changes in Activity Patterns or Routines	
30. Decreased activity	
Mental Status Changes	
31. Are there mental status changes that are due to pain and are not explained by another condition (e.g., delirium due to medication, etc.)?	
TOTAL SCORE (Add up checkmarks)	

Other Recent Evaluations of/ Developments about the PACSLAC

- The PACSLAC has been translated in at least 10 languages and has been studied in Dutch (PACSLAC-D), French (PACSLAC-F), Japanese (PACSLAC-J), Korean (PACSLAC-K) and Portoguese (PACSLAC-PT). It is being used around the world.
- Several literature reviews have evaluated the PACSLAC as being a leading assessment tool.
- Zwakhalen et al. (2006): In a systematic comparison of the PACSLAC, the PAINAD and the DOLOPLUS-II, the PACSLAC was rated by nurses as being the most useful measure.

Example of Pain Diary Using the PACSLAC



Other Recent Evaluations of/ Developments about the PACSLAC (cont'd)

- **Zwakhalen et al. (2006b): In a systematic comparison of the PACSLAC, the PAINAD and the DOLOPLUS-II, the PACSLAC was rated by nurses as being the most useful measure.**

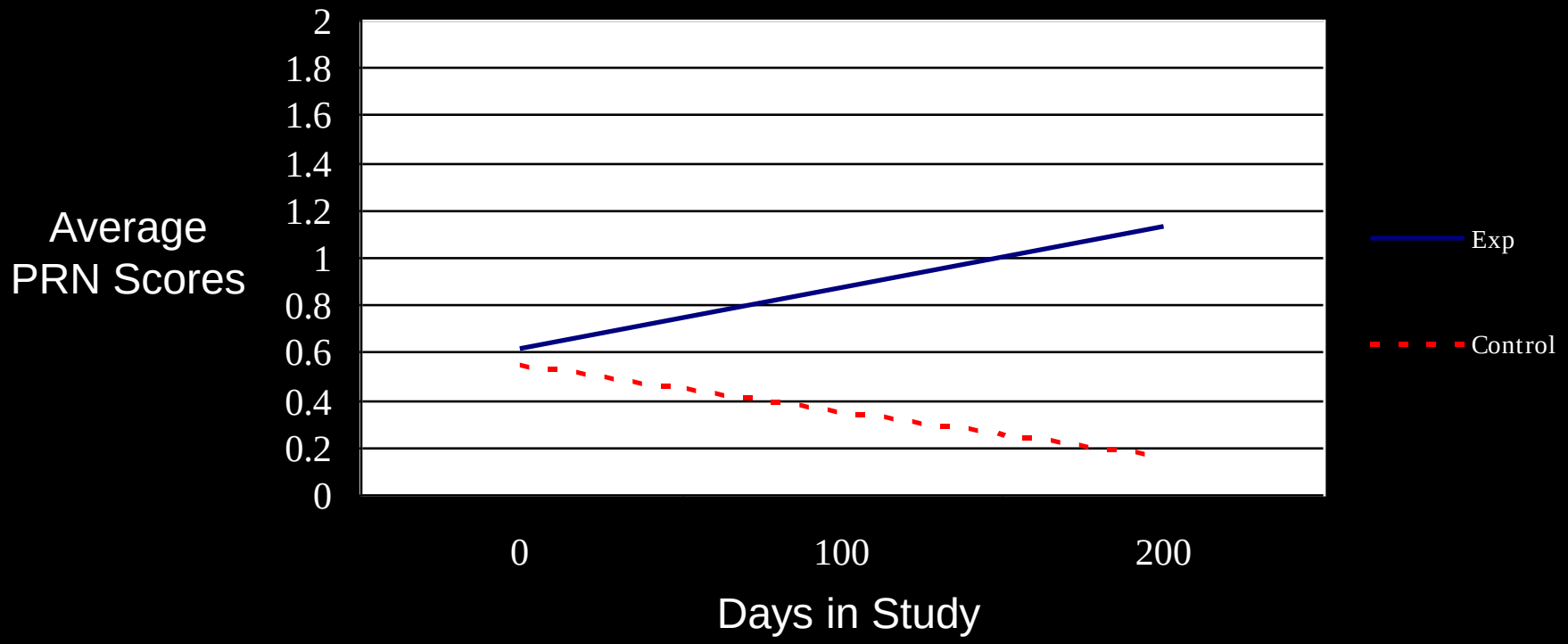
- **Recent research has demonstrated that the PACSLAC is discriminating painful from non-painful states better than other tools and that it has excellent potential for application with patients who present with delirium (Lints-Martindale et al., 2012).**

- **Recent research has demonstrated that the PACSLAC-II is discriminating painful from non-painful states better than other tools and that it has excellent potential for application with patients who present with delirium (Chan et al., 2014).**

Clinical Utility of the PACSLAC

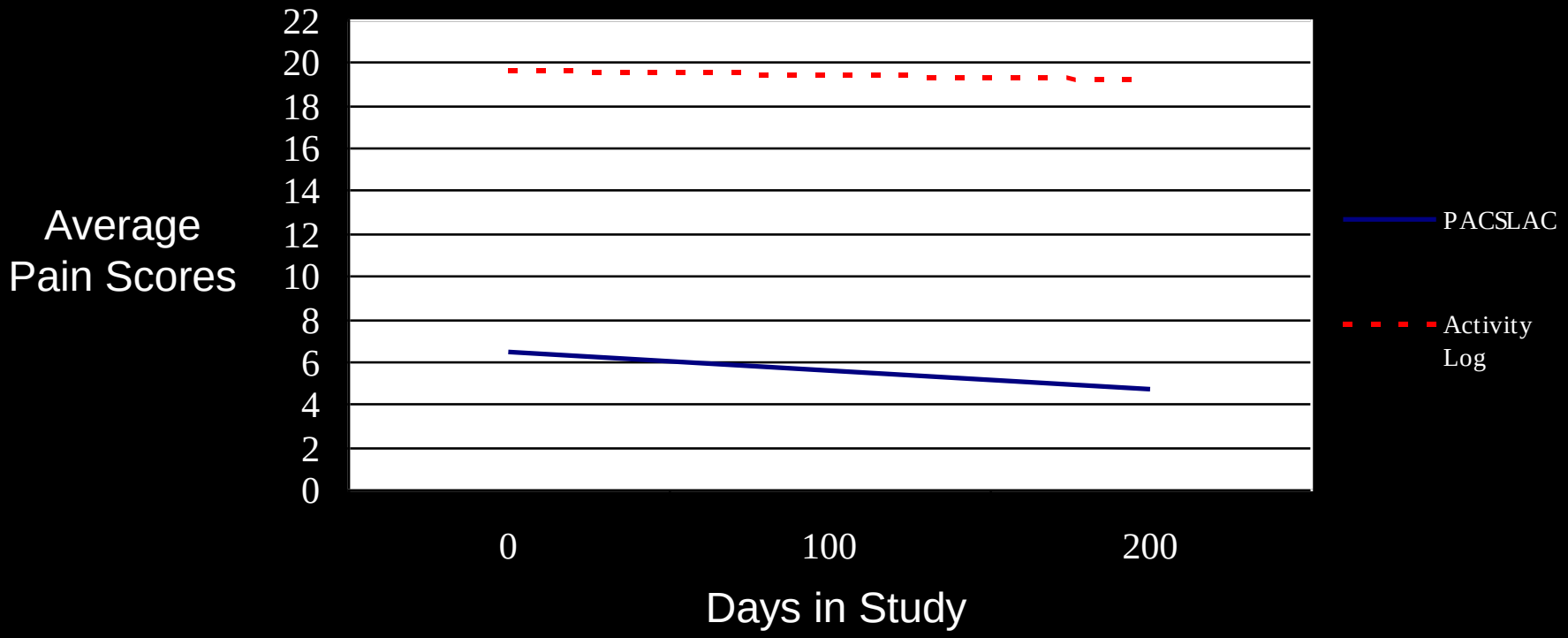
- Experimental Group: Nurses to Assess Pain Using the PACSLAC
- Control Group: Nurses to Complete a Non-Pain Relevant Checklist

Fuchs-Lacelle, Hadjistavropoulos & Lix, (2008)



Average PRN pain medication scores changes over time for patients in the Experimental and Control Groups

Fuchs-Lacelle, Hadjistavropoulos & Lix, (2008)



Average pain scores changes over time for patients in the Experimental and Control Groups

Fuchs-Lacelle, Hadjistavropoulos & Lix, (2008)

Nurse Stress and Burnout

Nurse stress and burnout scores in the experimental group reduced over time whereas those of the control group did not

Fuchs-Lacelle, Hadjistavropoulos & Lix, (2008)

Reducing unnecessary polymapharmacy with effective pain assessment

- We compared two very similar homes, one home using the PACSLAC/verbal report regularly with results communicated and discussed with the prescribing physicians and the other home not using the tool
- Pain levels were similar in the two homes but the patients in the pain assessment home were taking fewer benzodiazepines at the end of the study. (Hadjistavropoulos et al., 2014)

How to Best Assess Pain in Dementia Patients?

- Take into account patient history, physical examination results etc
- Use both self-report and observational approaches, if possible
- Seniors with mild to moderate dementia, can typically use the NRS and VRS (or another unidimensional tool)
- Use a good standardized non-verbal assessment scale such as the PACSLAC

From Hadjistavropoulos et al., (2007)

How to Best Assess Pain in Dementia Patients?

- Pain assessment during a movement-based task is more likely to identify an underlying persistent pain problem
- Examine whether use of analgesic medications results in a reduction of behavioural indicators of pain
- A comprehensive pain assessment includes evaluation of other aspects of patient functioning (e.g., mood).
- Solicit assistance of knowledgeable informants

From Hadjistavropoulos et al., (2007)

Using the PACSLAC/PACSLAC-II

- Use an individualized approach collecting baseline scores for each patient.
- Solicit the assistance of caregivers familiar with the patients.
- If assessment tools are used to monitor pain levels over time, they must be used under consistent circumstances (e.g., during a structured program of physiotherapy, over the course of a typical evening).
- The total score is more likely to be useful than subscale scores.
- The PACSLAC is a screening instrument and, as such, it cannot be considered to represent a definitive indicator of pain.

Comorbidities Can Complicate Pain Assessment

- Delirium
- Depression

What are some situations to assess pain?

- Over the course of a shift
- During a necessary but discomforting transfer
- During physical therapy

Thank You!!