



ASSESSING PAIN IN PEOPLE WITH DEMENTIA 2: THE NURSE'S ROLE

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This is the second in a two-part unit on dementia and pain assessment. The first part examined research on pain in people with dementia and the challenges nurses face with pain assessments. This part explores evidence on the methods and tools available to nurses and other care providers to use in pain assessment. It also outlines some practical implications.

PAIN ASSESSMENT

Over the past 10 years a variety of pain assessment tools have been developed, researched and presented. The issues around pain assessment tools concern reliability and validity, chiefly whether they accurately measure and represent pain and its intensity for people with dementia.

Working with existing abilities

Before considering behavioural pain assessment tools, it is important to work with the person's existing abilities. If the person is able to answer questions it is worth trying a verbal approach before moving to a behavioural assessment or asking a family member questions. The following points provide a general guide to the key areas of a pain assessment (Lothian Palliative Care Guidelines Group, 2004):

- The location of the pain;
- The severity;
- What exacerbates the pain;
- What alleviates the pain;
- What it feels like;
- How the pain is affecting the person.

A number of communication issues (outlined in the first part of the unit) that are worth considering for people with dementia:

- Nurses may need to ask the same question two or three times;

LEARNING OBJECTIVES

1. Consider a variety of potential methods/approaches for pain assessment in people with dementia
2. Understand the practical implications of person-centred care when assessing pain in people with dementia

- Someone who is known to the person with dementia may get the best response;
- A quiet area with minimal distraction may encourage the best response;
- Responses may vary from day to day or at different times; try another day or time;
- Consider the use of closed questions and avoid multiple questions. Keep things simple and give the person time to respond.

Person-centred approach

A fundamental aspect of dementia care key to pain assessment is the notion of person-centred care (Kitwood, 1997). This is about knowing and appreciating a person in her or his own right and adopting this approach in day-to-day care. For example, a person's history, likes, dislikes, relationships, work and values are taken on board in person-centred care.

In terms of pain assessment, this can take the form of knowing about and understanding previous experiences of pain or treatments. What language did the person use about pain? Were they stoical and never complained? Are there signs known from the past that identify or trigger pain? With this information, the task of assessment can be clearer. In a practical sense, this can mean discussion with a relative if a person is unable to provide this information directly.

Behavioural assessment of pain

As a person with dementia deteriorates and their verbal communication diminishes, a reliance on behavioural aspects is needed. The American Geriatrics Society (2002) has

developed guidelines that identify core elements that should be included in a behavioural assessment of pain:

- Facial expressions;
- Verbalisations/vocalisations;
- Body movements;
- Change in interpersonal interactions;
- Changes in activity patterns or routines;
- Changes in mental status.

A range of pain assessment tools focus on behavioural assessment. Herr et al (2004) reviewed 10 pain assessment tools for use with older people who cannot speak. Tools were evaluated by subject/setting reliability and validity, administration and ease of scoring, and their strengths and weaknesses described. This information is useful for professionals using a pain assessment tool for patients who are unable to speak.

Useful assessment tools

Two pain assessment tools that are frequently acknowledged in dementia care are the Abbey tool (Abbey et al, 2002), developed in Australia, and the Doloplus 2 (Lefebvre-Chapiro, 2001), a French tool.

The Abbey tool was positively reviewed by Herr et al (2004) in terms of its ease of use and reportedly took only one minute to complete. It was criticised in that further testing is required for reliability.

Also, the measuring of temperature and pulse was questioned – changes in these observations are not supported in the pain literature. A person with chronic pain (pain lasting more than six months) is unlikely to have altered vital signs as a result of their pain, so this measure was not considered to be valid.

The Doloplus 2 was described as 'a comprehensive tool based on sound assumptions of the multidimensionality of pain' (Herr et al, 2004). It received criticism, however, because it has not been fully tested in English-speaking countries.

It also assumes that carers can reliably rate an older person's pain. Herr et al (2004) argued that this is not the consistent view in the literature. This point is critical because

any assessment of pain by a carer is of a second-hand nature and does not represent the precise views or experience of the person in pain. However, where people with dementia cannot describe their experience, a behavioural assessment is necessary.

From Herr et al's (2004) work, it would seem that pain assessment tools have their limitations. No tool meets all requirements and is generally recognised as the best. This means that, when selecting a tool, nurses need to consider its appropriateness for particular clients and settings.

Despite these criticisms, tools can provide structure and focus to an assessment. Carers who do not have an assessment tool have to consider and identify behaviour that may be caused by pain and document their observations in a consistent, rigorous manner. To do this without criteria or guidance is challenging.

The consistency provided by an identified assessment tool is valuable when there are many carers, for example, in hospital. Varying shift patterns, grades of staff and knowledge about pain and dementia can result in the adoption of many different assessment techniques or none, and therefore varied and inconsistent information. This is a challenging area of care, so the adoption of a consistent, agreed approach is good practice.

IS IT PAIN OR DISTRESS?

Recent research by Regnard et al (2007) has raised broader and significant issues regarding the behavioural assessment of pain. Their study, which investigated the development of a distress assessment tool for people with severe communication difficulties, started from a broad base. The authors argued that research has shown no evidence that one cause of distress reliably produced specific behaviours in people with dementia. The means that identifying the broader issue of distress may be only the starting point in an assessment. The authors suggested that what have been described as pain assessment tools for dementia may actually be distress assessment tools. This highlights a need to question the possible cause of behaviours identified – is it pain or distress caused by something else?

Regnard et al (2007) highlighted damage from giving analgesia to someone not in pain – sedation, increased confusion and possibly opioid toxicity. It may be possible to take simple measures to ease distress, such as regular exercise and movement, and avoiding stiffness and discomfort, to avoid unnecessary pain medication.

WHO DOES THE ASSESSMENT?

A further interesting issue raised by Regnard et al (2007) was the perceptions of different carers regarding the same client. Carers who saw clients daily identified the highest number of signs and behaviours of distress, and those with less contact still managed to identify about two-thirds of instances

Different carers, however, identified additional cues and cumulatively a team of people identified the highest number of distress signs. Although it used a small sample of clients (n=10), the research shows the possible benefits of a group of carers being involved in assessment, building a fuller picture of distress. This indicates it is beneficial to involve a number of people who know the person well in assessment.

PRACTICAL IMPLICATIONS

The following principles, based on evidence, aim to give direction and ensure accuracy in the assessment of pain.

Use the person's existing abilities – if possible, ask and involve them directly, using clear, simple communication. Be prepared to repeat questions. Find out as much as possible about any previous pain –

KEY REFERENCES

- Abbey, J. et al** (2002) *Abbey Pain Scale*. Dementia Care Australia Pty Ltd. www.dementiacareaustralia.com.
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- Regnard, C. et al** (2007) Understanding distress in people with severe communication difficulties: developing and assessing the Disability Distress Assessment Tool (DisDAT). *Journal of Intellectual Disability Research*; 51: 4, 277–92.
- The full reference list for this article is on the Portfolio Pages on nursingtimes.net

how did they react? What words did they use for pain? What, if any, pain medication have they used? Is the problem due to pain or is there distress from another cause?

If the person cannot communicate, there may be a need to find information from someone who knows them well.

Think about possible causes of pain and treat specifically, for example, pressure areas or constipation. Nurses should find and use an assessment tool that meets the needs of the individual.

If a person is unable to communicate, a tool that assesses behaviour should be used (Herr et al, 2004). Using an assessment tool can provide a consistent, structured and rigorous approach, which is preferable to an assessment without criteria.

CONCLUSION

Completion of an accurate assessment is only the first step in addressing the problem of pain or distress a person with dementia is experiencing. This increases the potential for appropriate decisions to be made and to provide the most effective help. ■

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