

# Development of a Pain Assessment Tool for those with Cognitive Impairment

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# PENINSULA HEALTH



# Rosebud Residential Care Service

- Locally known as RRACS
- Site contains a low care and high care facility
- 50 Residents
  - 20 bed low care
  - 30 bed nursing home with 10 bed dementia wing
- Ageing in place
- CNC and portfolio reps — Falls, Skin Integrity, Infection Control, Contenance, Diabetes OH&S, BLS
- CNC cognition support



# Case Study

Mrs R

88 year lady

Primary diagnosis - vascular dementia

Past history – Trigeminal neuralgia, CVA, osteoarthritis

Behaviours noted

- Wanderer
- Intrusive
- Resistive to care
- Agitation and aggression
- Lack of insight into own safety
- Lack of insight into others needs

Falls risk



## Case Study

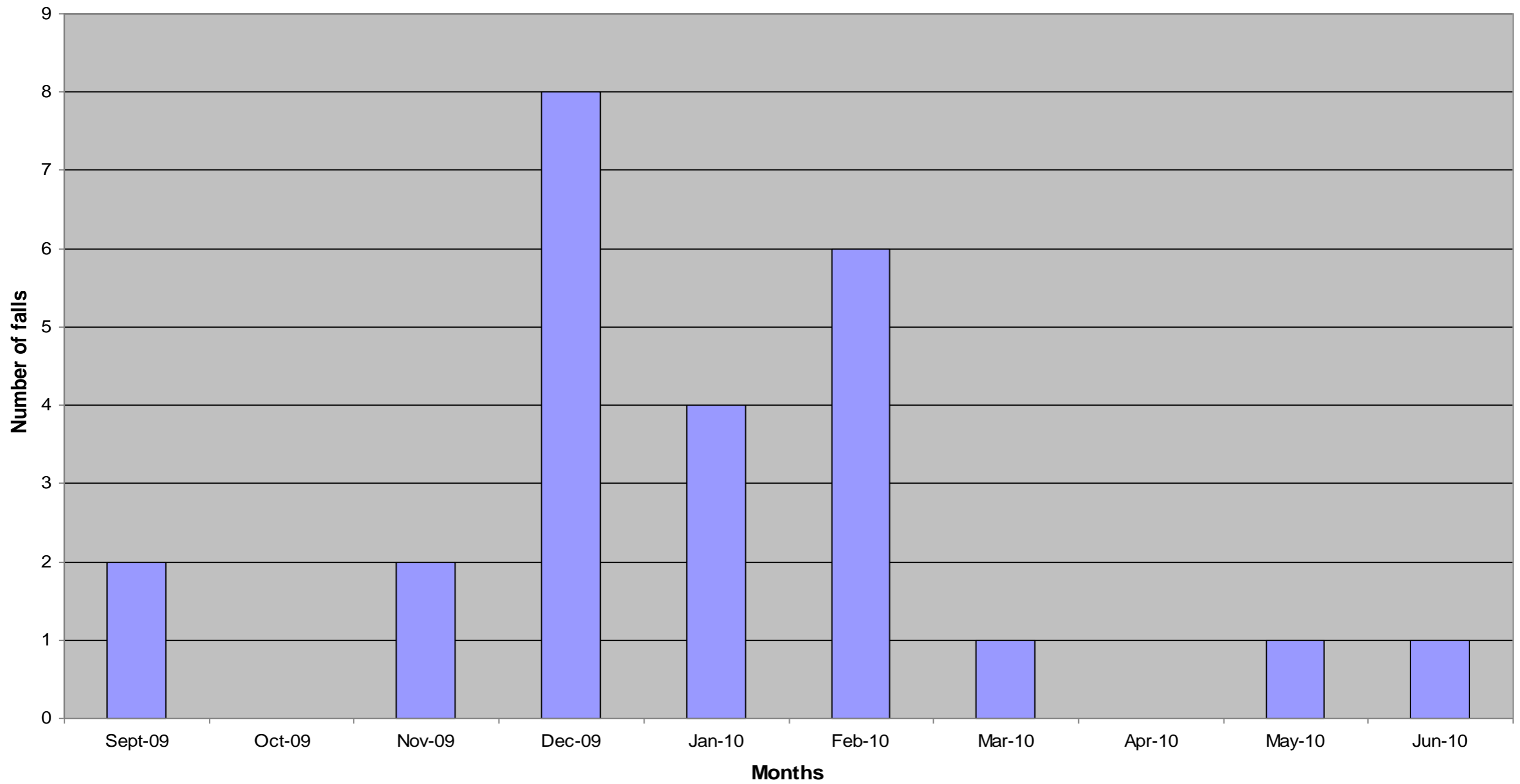
Mrs R was admitted to facility July 09 and settled into the facility but the facility was closed in Dec 09 for refurbishment

Residents were transferred to another Peninsula Health facility nearby.

At this point there was a marked escalation in both behaviours and falls.



Total Falls Sept 09 - June 10



# Fall with harm review

Sustained a fall on 4th June that resulted in suturing of lacerations

Critical incident review

- deterioration in condition of Mrs R and a lessening of BOC prior to this fall
- lifestyle and leisure activities had been increased
- GP review had been undertaken
- Implementation of low low bed



# Fall with harm review

Following the fall on the 4th June Mrs R was noted to be mobilising less and tending to lean when seated.

Family were concerned with deterioration in her condition and discussion was held with GP  
Bone scan was ordered and the result showed that Mrs R had healing rib fractures



# Falls with harm review

Team meeting re fracture of ribs

- Sustained a fall 13th May that resulted in facial bruising.
- Staff adamant no significant change in behaviour, ambulation or indications of pain.
- Documentary evidence of assessment and management of pain was not clear
- Delay in confirming bone scan results and notification on GP



# Issues raised

## Documentation

- Post fall observations

- Pain response

- Timely reporting response

## Pain Management

- Cognitive impairment

## Staff engagement

- Debrief

- Scope of practice issues

Anonymous complaint to the Aged Care Complaints Scheme



# Actions

Escalation to Chief Nurse

Post fall response

modified to include pain Ax

Audit of current documents for Pain Ax

cognitively intact ok

cognitively impaired -gap identified

Staff education gap identified



# Literature Search

## Best practice

- Not a good understanding of what the cognitively impaired person felt in regard to pain
- Agreement that pain leads to reduced quality of life, functioning in ADL's and increased risk of depression
- Agreement that pain was not well managed in health care facilities.



# Literature Search

## Assessment tools

A number of tools were available that were designed for the cognitively impaired.

Abbey pain tool currently in use in our health **service** -recommended by Cognition and Pain Service

Beaver Dam Community Hospital tool



# Implementation

Tool development

Chief Nurse, PNO, Falls CNC

Draft sent for comment;

Nurse managers, Nurse education, Falls, Pain and cognition services, Falls Steering committee, Clinical Nursing Council, RACS Quality meeting

Trial Tool –currently at two aged care sites

Education – Nurse Education and Falls CNC



PENINSULA HEALTH

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH ..... M F

Please fill in if no Patient Label available

Trial 5/5/11 - Print Code:14465

**ABBEY PAIN SCALE**

*For measurement of pain in people with dementia who cannot verbalise.*

How to use scale: While observing the patient, score questions 1 - 6

Latest pain relief was.....at.....hrs

	DATE				TIME			
<b>Q1. Vocalisation</b> e.g. whimpering, groaning, crying, gasps, grunts Absent - 0    Mild - 1    Moderate - 2    Severe - 3								
<b>Q2. Facial Expression</b> e.g. looking tense, frowning, grimacing, looking frightened, tightened lips, dropped jaw, clenched teeth Absent - 0    Mild - 1    Moderate - 2    Severe - 3								
<b>Q3. Change in body language</b> e.g. fidgeting, rocking, guarding part of body, withdrawn Absent - 0    Mild - 1    Moderate - 2    Severe - 3								
<b>Q4. Behavioural Change</b> e.g. increased confusion, refusing to eat, alteration in usual patterns, pacing, resistive to care Absent - 0    Mild - 1    Moderate - 2    Severe - 3								
<b>Q5. Physiological change</b> e.g. temperature, pulse, BP outside normal limits, perspiring, flushing, pallor Absent - 0    Mild - 1    Moderate - 2    Severe - 3								
<b>Q6. Physical Changes</b> e.g. skin tears, pressure areas, arthritis, contractures, fractures, previous injuries, change in level of activity Absent - 0    Mild - 1    Moderate - 2    Severe - 3								
Add scores for questions 1 - 6 and record here <b>Total Pain Score:</b>								
Now select the Total Pain Score & record →	0 - 2 No pain	3 - 7 Mild	8 - 13 Moderate	14 + Severe				
Finally, select the type of pain & record →	Chronic	Acute	Acute on Chronic					
Signature Print name Designation								

ABBEY PAIN SCALE

MR/035/05 TRIAL



**NON-MEDICATION INTERVENTION CODES**

**A. Rehab Services**

- 1 = Safety assessment
- 2 = Immobilisation of joints
- 3 = Strength & endurance

**C. Relaxation / distraction techniques**

- 1 = individual
- 2 = group
- 3 = 1:1 activities

**B. Physical modalities**

- 1 = heat
- 2 = ice
- 3 = massage

**D. Psychological & Social Support**

- 1 = family visits
- 2 = spiritual counselling
- 3 = other

**Possible causative factors:**

- 1 = over/under stimulated
- 2 = hot/cold
- 3 = hunger
- 4 = constipation
- 5 = UTI
- 6 = sleep disturbance
- 7 = Other (please state)

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH ..... M F

Please fill in if no Patient Label available

Draft prepared by S. Tesoriero 7/10/10

Permission to modify given by Beaver Dam Community Hospital Beaver Dam, Wis, August 2001

\*\* Post fall : every 30 minutes for 4 hours then QID for 3 days.

**PAIN MANAGEMENT FLOW SHEET FOR COGNITIVELY IMPAIRED**

Date / Time	Abbey Score	Non-Med intervention	Medication (tick if given - refer medication chart)	Follow-up monitoring of effective intervention and discomfort**			Initials	Comments / Possible causative factor
				Date	1 hour	Abbey Score		

PENINSULA HEALTH  
Abbey Pain Scale cont.

PATIENT NAME:  
UR NO.

# Observational indicators of pain

## Vocalisation

Whimpering, Groaning, Crying, Gasping, Grunting, Repetitive vocalisations, Yelling/screaming, increased vocalisation, use of profanity, words of protest, words of discomfort



## Facial expression

Looking tense, frowning, grimacing, looking frightened, tightened lips, dropped jaw, clenched teeth, wincing, narrow or closed eyes, looking sad



## Change in body language

Fidgeting, rocking, guarding part of body, withdrawn, restlessness and repositioning, rubbing, tense body language



## Physiological change

Temperature, pulse and respirations outside normal limits, perspiring, flushing, pallor, fatigue, Altered appetite, altered sleep pattern, noisy breathing, rapid eye blinking, shortness of breath



## Behavioural change

Increased confusion, Refusing to eat, Alteration in usual patterns, Pacing, Resistive to care, Aggression, Agitation/irritability, Attention seeking behaviour, Social withdrawal



## Physical changes

Skin tears, pressure areas, arthritis, contractures, fractures, previous injuries, changes in level of activity, limping, moving slower than normal.



## Pain assessment in the cognitively impaired using the Abbey Pain Scale MR 220.16



Post fall, as per neuro obs protocol - ½ hourly for 4 hours - QID for 3 days

Injury detected or staff concern — 1/2 hourly for 2 hours then review

Contact GP if reportable levels of pain are assessed

# Evaluation

Aged Care Complaints Scheme report

Focus group with staff – modification of the tool to improve usability

Audit tool is currently being developed as part of the implementation process

- Current completion of tool
- Correct usage within the guidelines of the post fall response



## Where to from here

- Extend the use of the tool into the sub acute wards
- Extend the use for other clinical risk areas especially skin integrity
- Adoption of tool use when there is demonstrated change of medical condition or change in demonstrated behaviours



# Acknowledgements

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**Staff of Rosebud Residential Aged Care Service**

