Whittington Health NHS

Pain Assessment for Patients with Moderate or Severe Cognitive Impairment

Subject:	Pain assessment for patients with moderate to severe cognitive impairment
Policy Number	N/A
Ratified By:	Clinical Guidelines Committee
Date Ratified:	25/08/10
Version:	2.0
Policy Executive Owner:	Director for Surgery, Cancer & Diagnostics
Designation of Author:	Pain clinical nurse specialist
Name of Assurance Committee:	Clinical Guidelines Committee
Date Issued:	September 2014
Review Date:	Three years hence
Target Audience:	All clinical staff
Key Words:	Pain assessment, cognitively impaired

Version Control Sheet

Version	Date	Author	Status	Comment
1.0	Aug/ Sept 2010	Jasmina Banicek Clinical Nurse Specialist- Acute Pain Service	Off-line	Due for review
2.0	Oct 2014	Jasmina Davies (was Banicek) Clinical Nurse Specialist- Acute Pain Service	Current	No changes

➢ Criteria for use

- Any adult patients with moderate or severe cognitive impairment who may not be able to self-report their pain.
- Other trust pain tools:

General	(available on intranet)
Paediatric	(available on intranet)
Critical Care	(available on intranet)

➢ Background/ introduction

- The best method of assessing pain is for the patient to 'self-report' the amount of pain experienced. Patients who are cognitively impaired may often be unable to express themselves adequately. This does not mean an absence of pain. The implementation of this pain assessment tool (See appendix I) will aid the assessment of pain in patients with cognitive impairment.

- Effective treatment of pain for all is a human right. In order to treat pain it must first be assessed as accurately as possible.

- Studies have found that in patients with cognitive impairment, pain is under-reported. Patients with dementia are known to receive fewer analgesics than others of similar age and pathology.

- For some groups of older people, it may be difficult to articulate their pain as for example some forms of stroke or Parkinson's disease.

- Self-report is the most reliable indicator of pain experienced, but if this is not possible a behavioural tool should be used to assess pain.

- This pain tool has been adapted from the Pain Assessment in Advanced Dementia (PAINAD) tool.

- The pain tool will be used with an analgesic guide to facilitate appropriate use of pain relief when a patient is in moderate to severe pain.

➢ Inclusion/ exclusion criteria

- This pain assessment tool is only intended for patients who have cognitive impairment and / or are unable to self-report.

- Patients able to self-report should use the existing general pain assessment tool (See appendix II).

➢ Clinical management

- Patients requiring regular analgesia or for whom pain has been identified as a potential or actual problem, either as part of their initial or ongoing assessment, should have their pain assessed on a regular basis.

- Each type of behaviour should be assessed and given a score.

- Each of the five behaviours needs to be assessed. This results in a total score out of 10. Each score correlates to a categorical pain rating score (‘none’, ‘mild’, ‘moderate’ or ‘severe’).
- If analgesia is required, suggested analgesic options are detailed on the chart. Prescribed medication should be given according to level of pain score.
- Non-pharmacological techniques also need to be considered such as re-positioning and physiotherapy to aid pain management
- After an intervention has been administered, pain levels must be re-assessed in one hour.

➢ Further information

	Please see: ***’The Acute Pain Handbook’*** http://whittnet/document.ashx?id=383

➢ Contacts

The Acute Pain Service (APS):

☞ The APS provides 24-hour cover in the management of acute & post-operative pain and supervision of analgesic methods implemented through the APS (e.g. PCA, Epidural Analgesia).

☞ **APS Team members:**

Lead Clinical Nurse Specialist: Diana Waterton
Clinical Nurse Specialist: Jasmina Davies
Clinical Nurse Specialist: Ruby Shaikh
(Ext: 5277 / Bleep: 2688)
Lead Consultant: Dr Samina Ishaq
Anaesthetic Consultant: Dr Basil Almahdi
(Aircall via switchboard)
1st On Call Anaesthetist, provides ‘out of hours’ pain service.
(Bleep: 3301)

➢ References

1. Warden V, Hurley AC, Volicer L. Development and Psychometric Evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc* 2003; 4 (1): 9-15.

2. Gibson SJ (Ed). *Pain: Clinical Updates*. IASP Press 2006. Vol: XIV, No: 3.

PAIN ASSESSMENT CHART

FOR PATIENTS **ABLE** TO SELF-REPORT

PAIN SCORES

(Assess at rest & on movement. Document highest score)

SEVERE PAIN

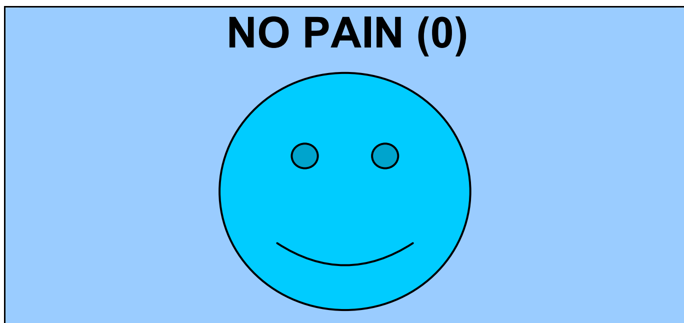
PARACETAMOL PO / IV / PR
+
NSAID (unless contraindicated)
+
STRONG OPIOID Oramorph ® (Oral)
Morphine Sulphate (SC/IM)
Diamorphine (SC)

MODERATE PAIN

PARACETAMOL PO / IV / PR
+
NSAID (unless contraindicated)
+
WEAK OPIOID Dihydrocodeine (Oral)
Codeine phosphate (Oral)
Tramadol (Oral/IM/IV)

MILD PAIN

PARACETAMOL PO / IV / PR
+ (If required)
NSAID (unless contraindicated)
Ibuprofen Oral
Diclofenac Oral / Rectal



NO PAIN

Continue to assess
pain, sedation and nausea scores
at least 4 hourly

SEDATION & NAUSEA SCORES

Sedation Score:	
Awake	= 0
Easily roused	= 1
Difficult to rouse	**= 2**
Unable to rouse	**= 3**

Nausea Score:	
No nausea	= 0
Mild nausea	**= 1**
Severe nausea	**= 2**
Vomiting	**= 3**

PAIN ASSESSMENT CHART

FOR PATIENTS WHO **CAN NOT** SELF-REPORT / COGNITIVE IMPAIRMENT

(Adapted from PAINAD, 2003)

	0	1	2
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
Muscle Tone	Normal muscle tone. Relaxed	Increased tone, Flexion of fingers and toes (clenched fists)	Rigid (stiff, tense tone)
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure
			TOTAL Out of 10

PHARMACOLOGICAL INTERVENTION (as prescribed)			
No pain (0)	**Mild pain (1-3)**	**Moderate pain (4-6)**	**Severe pain (7-10)**
Continue to assess pain, sedation and nausea scores	**PARACETAMOL** PO / IV / PR **+ (If required)** **NSAID** (unless contraindicated) Ibuprofen (Oral) Diclofenac (Oral / Rectal / IV)	**PARACETAMOL** PO / IV / PR **+** **NSAID** (unless contraindicated) **+** **WEAK OPIOID** Dihydrocodeine (Oral) Codeine phosphate (Oral) Tramadol (Oral/IM/IV)	**PARACETAMOL** PO / IV / PR **+** **NSAID** (unless contraindicated) **+** **STRONG OPIOID** Oramorph ® (Oral) Morphine Sulphate (SC/IM) Diamorphine (SC)

SEDATION & NAUSEA SCORES

Sedation Score:

Awake	= 0
Easily roused	= 1
Difficult to rouse	**= 2**
Unable to rouse	**= 3**

Nausea Score:

No nausea	= 0
Mild nausea	= 1
Severe nausea	**= 2**
Vomiting	**= 3**

- Pain, sedation & nausea scores must be performed and recorded at least every **FOUR HOURS**
- If any score is 2 or above an intervention(s) is (are) required, then reassess after **ONE** HOUR
- Details of any intervention(s) / persons contacted must be entered in the patient's notes
- If prescribed analgesia is ineffective contact medical team
- For further information you may refer to the Acute Pain Control Handbook (Located on the Intranet)

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the procedural document likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance	Yes	

	Title of document being reviewed:	Yes/No	Comments
	with the document?		
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

<table>
<tr><td colspan="4">Executive Sponsor Approval</td></tr>
<tr><td colspan="4">If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval</td></tr>
<tr><td>Name</td><td></td><td>Date</td><td></td></tr>
<tr><td>Signature</td><td colspan="3"></td></tr>
<tr><td colspan="4">Relevant Committee Approval</td></tr>
<tr><td colspan="4">The Director of Nursing and Patient Experience’s signature below confirms that this procedural document was ratified by the appropriate Governance Committee.</td></tr>
<tr><td>Name</td><td></td><td>Date</td><td></td></tr>
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<tr><td colspan="4">Responsible Committee Approval – only applies to reviewed procedural documents with minor changes</td></tr>
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<tr><td>Name of Committee</td><td></td><td>Name & role of Committee Chair</td><td></td></tr>
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Tool to Develop Monitoring Arrangements for Policies and guidelines

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/check/observe/Assess/inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
Training	Pain team, Practice development nurses	Training records	Annually	Annually
Implementation	Pain team, Visual leadership team	Audit	Annually	Annually