

Pain is often under reported and under-treated in many elderly patients and those patients with cognative impairment. Pain may present as agitation, increased calling out or other distressing behaviours.

Unsure of how to complete a pain assessment in your patient who has cognative impairment or may not be able to provide you with the subjective information that you need for a traditional OPQRSTUV pain assessment?

The NH PC Consultation Team supports the use of the <u>Pain Assessment in Advanced Dementia Scale Tool (PAINAD)</u> by clinicians to aid in the pain assessment of patients.

Instructions: Observe the patient for five minutes before scoring his or her behaviours. Score the behaviours according to the following chart. The patient can be observed under different conditions (e.g. at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

| Behaviour | 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 | |
| Total Score | | | | |

Add the values to obtain a total score, ranging from 0 to 10. The score indicates whether the person might be experiencing pain, higher scores more accurately indicate pain than lower scores. The score does not indicate the severity of pain.

