Pain Assessment in Advanced Dementia Scale (PAINAD)

Timeframe: July 11, 2018 to July 10, 2019

TEAM MEMBERS

Leader: **Elizabeth Watson RN,** Members: **Lacey Larson RN, Carla Brock, Bobbi Lucklum PT, Kathy Roti RN, Janice Christensen RN, Melissa Heinen RN, Karen Decker RN, Sheri Beckwith RN, Kelsey Fuchs RN, Karen Janes RN, and Kay Williams**

The Affordable Care Act led the Centers for Medicare and Medicaid Services to start hospice quality reporting programs. The Hospice Information Set (HIS) started July 2014 and is required for all admissions and discharges, regardless of the payer source. The quality measures are: Pain Assessment, Pain Intervention, Patients treated with an opioid are given a bowel regimen, Dyspnea Assessment, Dyspnea Treatment, Treatment preferences, Beliefs/Values Addressed, and the Number of visits patient received by RN, doctor, social worker, chaplain, and aide in the last 7 days of life and the last 3 days of life. These measures are published publically on the Hospice Compare website.

IDENTIFIED OPPORTUNITIES FOR IMPROVEMENT

Huron Regional Medical Center Community Hospice was lower than the national average for two of the hospice quality measures on the hospice information set:

1. Number of patients who were checked for pain at the beginning of hospice care.
2. Number of patients who received a timely and thorough pain assessment when pain was identified as a problem.

Hospice staff utilized the Hospice Patient Stay-Level Quality Measure report and completed a chart audit of 30 patients from the time frame of 01/01/2018 to 06/30/2018. This determined that comprehensive assessments were not completed on patients unable to communicate pain.

OBJECTIVE

Research and implement a standardized pain scale to use in non-verbal patients to improve pain management and quality of hospice are.

RESEARCH AND REFERENCE MATERIALS

1. Hospice Compare
2. Horgas, A. & Miller, L. (2008). Pain Assessment in People with Dementia. AJ, Vol. 107(7).
3. Kerr, K., Coyne, P., McCaffery, M., Manworren, R., & Merkel, S. (2011). Pain Assessment in the Patient Unable to Self-Report: Position Statement with Clinical Practice Recommendations. Pain Management Nursing. Vol12 (No. 4), pages 230-250.
4. Herr, K., Bjoro, K., Decker, S. Tools for Assessments of Pain in Nonverbal Older Adults with Dementia: A State-of-the-Science Review. (2005). U.S. Cancer Pain Relief Committee. Elsevier Inc.
5. Casper Reports

DATA

1. Hospice Casper Report Hospice-Level Quality Measure Report: Patients who were checked for pain at the beginning of hospice care (Pain Screening NQF #1634)
    a. Reporting period: 01/01/2018-6/30/2018 81.5%
    b. Reporting period: 07/01/2018-12/31/2018 77.4%
    c. Reporting period: 01/01/2019-05/31/2019 95%
2. Hospice Casper Report Hospice-Level Quality Measure Report: Patient who received a timely and thorough pain assessment when pain was identified as a problem (Pain Assessment NQF #1639)
    a. Reporting period: 01/01/2018-6/30/2018 68.2%
    b. Reporting period: 07/01/2018-12/31/2018 75%
    c. Reporting period: 01/01/2019-05/31/2019 93.8%

FINDINGS

Research was completed and found the Pain Assessment in Advanced Dementia Scale (PAINAD) was a simple, reliable and valid tool.

IMPLEMENTATION

All hospice patient care staff completed education on pain assessments and use of PAINAD scale. After education was completed the hospice staff decided to use the tool on all hospice patients who were unable to self-report pain. It was decided that the PAINAD score would be placed on these patients' plan of cares and updated every nursing visit. The goal rating was determined by family as mild, moderate, or severe in order for the hospice team to determine when an intervention was warranted.

CONCLUSION

The PAINAD scale was implemented and chart audits were completed monthly for patients who were unable to self-report pain. This was implemented 100% and the Hospice Casper Report Hospice-Level Quality Measure Report shows the significant increase and upward trend.

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

Behavior	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	

(Warden et al., 2003)

Scoring:

The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

Source:

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.

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PAINAD Item Definitions (Warden et al., 2003)

Breathing

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization

1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. Smiling or inexpressive. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. No need to console is characterized by a sense of well-being. The person appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. Unable to console, distract, or reassure is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.