Pain and Dementia

BE THE DETECTIVE

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BE THE DETECTIVE

- As care providers who are responsible for the day-to-day management of the individual with Dementia, we often find ourselves being the Detective. Our Detective work involves identifying clues by using our 4-senses that leads us to solve the case. Unsolved cases can manifest into behaviors or interactions that can be negative and misunderstood. Delays in care can lead to preventable hospitalizations and unforeseen injuries.

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LEARNING OBJECTIVES:

- The identification of pain is a collaborative and holistic approach by all who interact with the individual
- Observe/assess for signs of pain using our 4 senses
- Identifying verbal/non verbal communication
- Identifying behaviors associated with pain
- Identifying the location of pain
- Implement pharmacological and non-pharmacological interventions
- Create an individualized plan to address pain

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VITAL SIGNS:

BP, HR, RR, Temp, o2 saturation, weight

- Objective vs. Subjective
- Gives a concrete measurement that can be tracked for trends and changes
- Utilizes technology/equipment to accurately measure

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NORMAL VITAL SIGNS IN ADULTS

CORE TEMPERATURE	98.6°F (37°C)
HEART RATE	60–100 beats per minute
RESPIRATORY RATE	12–18 breaths per minute
BLOOD OXYGEN	95–100%
BLOOD PRESSURE	120/80 mm Hg

PAIN: THE 7TH VITAL SIGN

- Subjective vs. Objective
- Cognitively intact individuals can also experience difficulties explaining the level of pain, location and quality
- QUESTION…has anyone ever experienced pain that was indescribable?

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Traditional pain scale examples:

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Advanced Dementia Pain Scale

Pain Assessment in Advanced Dementia (PAINAD) SCALE			
Criteria	**Score 0**	**Score 1**	**Score 2**
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 of 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

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OBSERVATION AND ASSESSMENT

- Verbal communication
  - Talking
  - Moaning/groaning
  - Yelling
  - Crying
- Non-verbal communication
  - Body language
  - Nodding head yes/no
  - Facial expressions
  - Guarding
  - Speed of movement
  - Favoring (leaning, not using certain body parts)

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OBSERVATION AND ASSESSMENT

- Behaviors
  - Agitation
  - Aggression
  - Spitting
  - Crying
  - Yelling
  - Isolation

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USE YOUR 4 SENSES

- DO YOU HEAR THAT?
- DO YOU SEE THAT?
- DO YOU SMELL THAT?
- DO YOU FEEL THAT?

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Case Study #1

Mrs. Jones is an 89 year old female resident who resides in the memory care neighborhood. Mrs. Jones has Dementia and is non-verbal with expressive and receptive Aphasia. She is a pleasant resident without behaviors. Mrs. Jones requires some physical assistance with dressing/bathing, but can toilet on her own. She is continent of BM and is occasionally incontinent of urine needing a light pad. She needs set-up and cueing for grooming, ambulates independently using a walker, wears glasses, uses hearing aids and has all of her natural teeth. Mrs. Jones can feed herself a regular diet, has a hearty appetite and loves sweets especially hard candy. Her daughter allows the co-workers to "trick-or-treat" in her apartment. Mrs. Jones has a past medical history of Hypertension, Congestive Heart Failure, Hyperlipidemia, a history of UTIs and a history of falls. She is 5' 6" tall and weighs approximately 225lbs. Mrs. Jones participates in all dining experiences as well as group activities. She especially likes to attend church, happy hour and enjoys the outdoors.

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CLUES...CLUES...CLUES...

Over the last 2 weeks Mrs. Jones has not been herself. The dining staff reports that she has come later to meals and is only eating about 50% of her meals. When offered ice cream she eats 100%. The housekeeper reports that Mrs. Jones ambulates much slower these days and goes right back to her apartment after meals. Activities reports that she hasn't been to church for 2 weeks and has only attended 2 happy hours this week and last week.

This information was brought to the attention of the Director of Nursing during our weekly wellness meeting.

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THE INVESTIGATION CONTINUES…

The Director of Nursing and the Executive Director arrive to the residents apartment mid-morning. They immediately smell a foul odor, see candy wrappers on the floor and the resident is still in bed. A set of vitals were taken BP 105/65 HR 102 RR 22 Temp 100.3 o2 saturation 95% on room air. The residents weight was taken this morning and it read 219lbs. The staff was able to get the resident out of bed and a head-to-toe assessment was completed by the nurse.

During the transfer the team noticed that Mrs. Jones was moving very slow, her face was tense and looked sad, she was hunched over and wouldn't stand up straight. The nurse continued her assessment; +ROM to all extremities, no abdominal pain when her stomach was palpated, all skin intact, no swelling to her extremities and her lungs are clear of adventitious sounds.

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CLUES…CLUES…CLUES…

Mrs. Jones ambulates into the bathroom. She uses the restroom without difficulty then stands at the sink. As she normally does she brushes her hair, washes her face, puts on her glasses and puts in her hearing aids. This time she forgot to brush her teeth. The care giver handed Mrs. Jones her tooth brush. Mrs. Jones became agitated, swatted the tooth brush out of the care givers hand then began to scream and cry.

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CASE SOLVED

The nurse observed the right side of the lower jaw and noted some swelling and redness to the face. The nurse attempted to touch this area, but Mrs. Jones immediately guarded her face with her left arm then swatted at the nurse with her right hand. The nurse asked Mrs. Jones if she would like a piece of candy. She nodded her head in a yes motion. The nurse opened the candy and asked the resident to open her mouth. The resident opened her mouth and to the right side of the lower jaw was a broken tooth along with redness and swelling. The nurse also smelled a foul odor coming from the residents mouth. The nurse gave the resident the candy.

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INVESTIGATION DE-BRIEFING

- Personality change
- Temp 100.3 HR 102 RR 22 BP 105/65 weight loss (sepsis)
- Eating only 50% of regular meal
- Prefers cold ice cream and eats 100%
- LOVES hard candy
- Ambulating slowly
- Face is tense
- Hunched over
- Foul odor in apartment
- Swatted at the care giver, screamed then cried
- Missed church and happy hour

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INTERVENTIONS

- Dental visit/PCP notification

Non-pharmacological

- Ice packs
- Soft diet
- Cold beverages
- Increase fluid intake due to infection

Pharmacological

- Antibiotic Therapy
- Pain management
  - Analgesics (Tylenol)
  - Narcotics (monitor for increased falls and change in mental status)

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Case Study #2

Mr. Smith is a 92 year old male resident who resides in the memory care neighborhood. Mr. Smith has Dementia and is non-verbal with expressive and receptive Aphasia. Mr. Jones is pleasant, but experiences anxiety from time to time. Mr. Smith needs stand-by assistance with dressing and bathing. Mr. Smith can toilet on his own and is continent of bowel and bladder. Mr. Smith often wakes up in the middle of the night to use the bathroom. Mr. Smith ambulates unassisted. Mr. Smith wears glasses that are kept on the medication cart overnight and given to him in the morning. Mr. Smith has a past medical history of Hypertension and Hypothyroidism. Mr. Smith is 6' 0" tall and weights approximately 195lbs. Mr. Jones is active and enjoys walking, gardening and exercise class. Mr. Smith was a high school basketball star and coached at his Alma Mater.

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CLUES...CLUES...CLUES...

Over the last 2 days Mr. Smith has not been himself. The Fitness Instructor reported that Mr. Smith has attended exercise class, but has not participated. The Maintenance Director reported that Mr. Smith has been watering the vegetable garden, however he has been sitting down while doing so. The housekeeper reported that Mr. Smith hasn't taken his usual walk around the court yard.

This information was brought to the attention of the Director of Nursing during our weekly wellness meeting.

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THE INVESTIGATION CONTINUES…

The Director of Nursing and the Executive Director arrive to the residents apartment mid-morning. Mr. Smith was in the bathroom sitting on the commode. He was having trouble putting on his pants. The care giver attempted to assist, but Mr. Smith became anxious pushing away the care giver. Mr. Smith began to cry. Mr. Smith sat back down on the commode and covered his right leg with his pants. The nurse convinced Mr. Smith to allow her to help put on his pants. While pulling up his pants a large, purple bruise was observed to his right hip. A set of vitals were taken BP 165/90 HR 110, RR 25, Temp 98.5 o2 saturation 98% on room air. The residents weight was taken this morning and it was unchanged from the month before.

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CLUES…CLUES…CLUES…

Mr. Smith was not wearing his glasses. An environmental assessment was completed of Mr. Smith's apartment. Mr. Smith's arm chair was lying on it's side and the plant on the side table was on the floor.

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CASE SOLVED

An x-ray of the right hip was obtained and revealed that Mr. Smith has a fracture to the right femur bone. It appears that Mr. Smith had woken up in the middle of the night to use the bathroom. He didn't have on his glasses and the apartment was darkened. Mr. Smith fell over his arm chair and knocked his plant on the side table over.

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INVESTIGATION DE-BRIEFING

- Personality change
- Decreased participation in exercise class
- Missed his usual walk
- Watered the vegetable garden sitting down
- Temp 98.6 HR 110 BP 165/90 RR 25 no change in weight
- Increased anxiety
- Crying
- Guarding covering his right leg with his pants
- Bruise to the right hip
- Not wearing his glasses
- Furniture out of place

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INTERVENTIONS

- PCP notification/ Obtain x-ray on-site/ HOSPITAL TRANSFER

Non-pharmacological

- Ice packs
- Position for comfort
- Use a wheelchair for mobility
- Increase fluid intake (rule out UTI)

Pharmacological

- Pain management
  - Analgesics (Tylenol)
  - Narcotics (monitor for increased falls and change in mental status)

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Thank you for learning and growing with Senior Living U

Amy L. Magbulos, RN DN/CM

Senior Living University Presenter

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