GPs are encouraged to support nursing home staff in delivering better pain assessment and treatment in dementia, by following these Top Tips.

1. Refer to the patient’s notes to establish whether a pain assessment has been undertaken and documented. If not, observe the patient for the following potential indicators of pain:
   - Facial expressions
   - Verbalisation/vocalisations
   - Body movements
   - Altered interpersonal interactions
   - Changes in activity patterns or routines
   - Mental status changes
   - Physiological changes


3. Adopt a multi-modal approach to pain management. Consider prescribing oral and topical treatments (e.g. oral paracetamol with ibuprofen gel) and consider adjuvant analgesics if appropriate.

4. Consider liquids first-line if the patient has difficulty swallowing tablets or compliance issues.

5. Always prescribe laxatives with opiates. Monitor constipation and treat early.

6. Do not prescribe antipsychotics for dementia patients with behavioural symptoms if you suspect that pain is involved. Assess and treat pain using analgesia, and then review effect.

7. Consider the morphine equivalence when prescribing analgesic patches:

| Transdermal opioids: Approximate equivalence with oral morphine¹ |
|---------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Oral morphine equivalent (mg/24hrs) | 10  | 15  | 30  | 45  | 60  | 90  | 120 | 180 | 270 | 360 |
| Transdermal buprenorphine (mcg/hr) | BuTrans | BuTrans | BuTrans | - | 35 | Transtec | Transtec | Transtec | - | - | - |
| Transdermal fentanyl (mcg/hr) | - | - | - | 12 | - | 25 | - | 50 | 75 | 100 |

8. Consider non-pharmacological therapies (e.g. TENS, heat pads, massage, aromatherapy) when reviewing pain management.

9. Remember the maxim that if a person without dementia has pain from a certain disease, then a person with dementia is likely to have pain too.
Abbey Pain Scale

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

How to use scale: While observing the resident, score questions 1 to 6.
Name of resident: ___________________________________________________________
Name and designation of person completing the scale: ___________________________
Date: ...........................................  Time: ...........................................
Latest pain relief given was: ........................................................................... at........... hrs.

Q1. Vocalisation
   eg whimpering, groaning, crying
   Absent 0  Mild 1  Moderate 2  Severe 3

Q2. Facial expression
   eg looking tense, frowning, grimacing, looking frightened
   Absent 0  Mild 1  Moderate 2  Severe 3

Q3. Change in body language
   eg fidgeting, rocking, guarding part of body, withdrawn
   Absent 0  Mild 1  Moderate 2  Severe 3

Q4. Behavioural Change
   eg increased confusion, refusing to eat, alteration in usual patterns
   Absent 0  Mild 1  Moderate 2  Severe 3

Q5. Physiological change
   eg temperature, pulse or blood pressure outside normal limits,
   perspiring, flushing or pallor
   Absent 0  Mild 1  Moderate 2  Severe 3

Q6. Physical changes
   eg skin tears, pressure areas, arthritis, contractures,
   previous injuries
   Absent 0  Mild 1  Moderate 2  Severe 3

Add scores for 1 - 6 and record here .........................................................

Total Pain Score

Now tick the box that matches the Total Pain Score

0 - 2  3 - 7  8 - 13  14 +
No pain  Mild  Moderate  Severe

Finally, tick the box which matches the type of pain

Chronic  Acute  Acute on Chronic

Published by the JJ & JD Genn Medical Research Foundation 1999 - 2000
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