

Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

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# BP Blogger

## Myth Busting: Dementia Care Issue

What do we know about assessing pain in residents with dementia?



### Myth 1: They can't express their pain

There is increasing evidence that pain is undermanaged in older adults with dementia. Those with dementias tend to receive lower doses and less frequent pain medications despite having the same medical conditions that cause pain. Researchers are recommending that Behaviour Observation Methods such as the PACSLAC and DOLOPLUS-2 tools be part of comprehensive pain assessments especially for those with dementia and are unable to communicate verbally. For most residents, behavioural observation methods do detect the majority of pain (presence or absence of pain). They will not detect the severity of the pain; nor measure the effectiveness of a pain treatment of intervention.

Mild to Moderate Dementia	Severe Dementia
<ul style="list-style-type: none"> <li>• Can provide valid reports of pain</li> <li>• Tend to underreport their pain related to problems with                             <ul style="list-style-type: none"> <li>• Recalling, interpreting and communicating their pain</li> </ul> </li> <li>• Pain can usually be measured by                             <ul style="list-style-type: none"> <li>• Self-report measures (pain intensity), have difficulty interpreting Faces Pain Scale</li> <li>• Care-provider observation reports</li> <li>• Formalized pain behaviour scales</li> </ul> </li> <li>• There is an association between self-reported pain and behaviour scales</li> <li>• Depression results in higher pain observations and pain behaviour scores</li> <li>• Care-provider may misinterpret pain-related behaviour as something else</li> </ul>	<ul style="list-style-type: none"> <li>• Cannot clearly communicate                             <ul style="list-style-type: none"> <li>• Presence of pain</li> <li>• Level of pain</li> </ul> </li> <li>• Self-reports may be inaccurate</li> <li>• Communication deteriorates</li> <li>• Recall inaccuracy increases</li> <li>• Incorrect completion of pain measures increases</li> <li>• Subtle behavioural changes are best noticed by staff who care consistently for the resident</li> <li>• Behaviour observation methods offer a strategy to improve pain assessment</li> <li>• Ability to recognize and respond appropriately to pain is a cognitive function and is affected by dementia.</li> </ul>

Level of Cognitive Impairment				
Which Pain Tools to Use		Mild	Moderate	Severe
Intensity	Visual Analogue Scales <small>Thermometer, Colour</small>	✓	✓	✗
	Numerical Rating Scales <small>1-10 Rating</small>	✓	✗	✗
	Faces Scale	✓	✗	✗
Presence	Behaviour Observation	✗	✓	✓

### Myth 2: It's okay when they say no to oral care

Oral health is important for residents with dementia because it affects their quality of life, ability to chew and speak, and nutrition and hydration. There is abundant international evidence showing that institutionalized older adults and especially those with dementia have the poorest oral health of nearly any group in society. Those with dementia have more dental plaque, higher debris in their mouths, poorer periodontal condition, higher dental caries, more unrestorable teeth, fewer filled and sound teeth, and less often have dentures or have older, dirtier dentures. Their ability to practice daily oral care may gradually weaken and those with moderate to severe

dementia will need substantial help to complete their oral care. Oral care can unintentionally become a low priority among all the care needs for residents with resistive care behaviours. The repeated refusals of oral care and the preference to eat sweet foods results in the building of dental plaque, tooth decay, oral pain and infections. Oral pain may trigger resistive behaviours. It's critical for general and oral health that daily oral care is completed. Declining oral health could make residents susceptible to delirium. Individualized oral care plans should describe with details how oral care is best done for each resident.

Inside this issue:

- Myth 1:** 1  
They can't express their pain
- Myth 2:** 1  
It's okay when they say no to oral care
- Myth 3:** 2  
They eat with no problems
- Myth 4:** 2  
Music doesn't work

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Check out these related back issues

- PAIN Jan 2007,
- MOUTH CARE Apr 2007,
- SWALLOWING Jul-Aug 2007

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- BPGs and Resources** 2
- Contacts for Information** 1 & 2

**More information on This and Other Best Practices**

- **Contact** your **Regional LTC Best Practices Coordinator**. They can help you with Best Practices Info for LTC. **Find them at:**
- [www.rgpc.ca](http://www.rgpc.ca)  
Click on Long Term Care
- [www.shrtn.on.ca](http://www.shrtn.on.ca)  
Click on Seniors Health
- **Check out** the **Hamilton Long Term Care Resource Centre** [www.rgpc.ca](http://www.rgpc.ca)
- **Surf the Web** for BPGs. Some sites and resources are listed on pg 2.
- Review back issues of the BP Blogger for related topics [www.rgpc.ca](http://www.rgpc.ca)

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## Myth 3: They eat with no problems

or motor problems (or a combination of these). For residents with dementia, the consequence of dysphagia may be dehydration, malnutrition, and weight loss. Cognitive changes can produce confusion and lack of recognition of the meaning of food. Aspiration of food or secretions predisposes residents to respiratory complications, such as aspiration pneumonia.

### The following techniques optimize hydration and nutrition for the residents with dysphagia and dementia:

- good oral hygiene
- a consistent environment, seated in same area in the dining room for mealtime/eating
- encouraging 6 small meals and hydration "breaks" per day rather than 3 meals per day
- including foods that are spicy, sweet, and sour to maximize sensory input
- consulting with a registered dietician about appropriate high calorie snacks
- consulting with SLP to determine consistency and appropriateness of food and liquids, feeding techniques
- encouraging self-feeding and providing food choices
- not allowing staff to be called away during meals when they are assisting residents with meals or snacks
- eliminating non-food items (distractions) from tables/trays
- making food visually appealing
- allowing residents to touch food if they wish
- not making residents wait when they arrive for meals

A resident's degree of functional dependency is an important factor in predicting risk of aspiration pneumonia. Residents' dementia-related changes in swallowing ability include the inability to feed themselves, increased time holding food in the mouth, less chewing, delayed swallowing, inconsistent airway protection, coughing with liquids, choking, poor tongue control while eating, and absence of chewing.



## Myth 4: Music doesn't work

There is enough supportive evidence to recommend the use of music as an intervention in the care of residents with dementia. It's the intentional use of group or individual music interventions for the

prevention and treatment of agitated behaviours.

### Studies have shown that:

- Music interventions may decrease the need for environmental and chemical restraints, and
- A music intervention is easy to incorporate into daily care, and it's inexpensive and non-invasive.

The expected benefit of individualized music is related to the identification and implementation of music based the resident's specific music preference. Play what they know and like.

Individualized music may not be appropriate for everyone. For example, it may not be effective in residents who have not had an appreciation

for music. The more important music was during a resident's life prior to their dementia, it is expected that the music intervention will be effective.

### Check out these Best Practices & Guidelines. Answers to the Myths came from them. Find out more!

#### Canadian:

Hadjistravropoulos, T., et al. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. *Clin J Pain*, 23(1) January Supplement, S1-S43.

Kaasalainen, S. (2007). Pain assessment in older adults with dementia. Using behavioural observation methods in clinical practice. *Journal of Gerontological Nursing*, 33, 6-10.

Kaasalainen, S., & Crook, J. (2004). An exploration of seniors' ability to report pain. *Clinical Nursing Research*, 13, 199-215.

Kaasalainen, S., & Crook, J. (2003). A comparison of pain-assessment tool for use with elderly long-term care residents. *Canadian Journal of Nursing Research*, 35(4), 58-71.

MAREP (2006). Oral health and dementia. *Innovations: Enhancing Ability in Dementia Care*, 5(2), 1-3.

Registered Nurses Association of Ontario. (2008). *Assessment and management of pain*. Toronto, ON: Author. [www.rnao.org](http://www.rnao.org)

#### Other:

Alzheimer's Association (South Australia), Australian Dental Association and Colgate Oral Care (2002). *Oral Care. Tips for Residential Care Staff*.

Alzheimer's Association (2006). *Dementia care practice recommendations for assisted living residences and nursing homes. Phase 1 & 2. Chapter 1. Adequate Food and Fluid Consumption 2. Pain Management*. Washington, DC: Author.

American Medical Directors Association. (2003). *Pain management in the long-term care setting. Clinical practice*. Columbia, MD: Author. [www.amda.com](http://www.amda.com)

Chalmers, J.M. & Ettinger, R.L. (2008). Public health issues in geriatric dentistry in the United States. *The Dental Clinics of North America*, 52, 423-446.

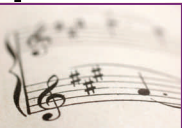
Chalmers, J. M., and Pearson, A. (2005). A systematic review of oral health assessment by nurses and carers for residents with dementia in residential care facilities. *Spec Care Dentist*, 25 (5), 227-233.

Easterling, C.S., and Robbins, E. (2008). Dementia and Dysphagia. *Geriatric Nursing*, 29, 275-185.

Gerdner, L. (2007). *Individualized music for elders with dementia*. Iowa City: University of Iowa Gerontological Nursing Interventions Research Center, Research Translation Dissemination Core.

Gerdner, L. (1997). An individualized music intervention for agitation. *Journal of the American Psychiatric Nurses Association*, 3, 177-184.

Witzke, J., Rhone, R.A., Backhaus, D., & Shaver, N.A. (2008). How Sweet the Sound: Research Evidence for the Use of Music in Alzheimer's Dementia. *Journal of Gerontological Nursing*, 34(10), 45-52.



After determining residents who are at greatest risk for agitation and ensuring that treatable causes of agitation, such as pain are ruled out, the following steps or guidelines may be used in implementing individualized music:

- Individualize music to resident's preferences
- Optimal effectiveness is achieved by implementing the intervention a minimum of 30 minutes prior to the resident's usual peak level of agitation
- Play the music using the following procedures:
  - Choose medium for delivering music (e.g, radio);
  - Each music intervention session should last approximately 30 minutes in a location where the resident spends the majority of his or her time;
  - The volume or loudness of music must be set at an appropriate level;
  - Music is generally presented "free field" (convert to headphones if necessary)
- An ongoing assessment should be conducted to determine resident's response to the music intervention.
  - Monitor the resident while the music is playing to ensure that agitation does not increase or confusion becomes more pronounced. (it should be minimized) If the resident begins exhibiting an increased frequency of agitation with the onset of music, the music should be stopped immediately.
  - Family should be consulted; and
  - Music that is pleasing to one resident may be annoying to another. Monitor for this.

Gerdner (2007, 1997)

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