

Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)

DATE: _____ TIME ASSESSED: _____ NAME OF PATIENT/RESIDENT: _____

PURPOSE: This checklist is used to assess pain in patients/residents who have dementia and are unable to communicate verbally.

INSTRUCTIONS: Indicate with a checkmark, which of the items on the PACSLAC occurred during the period of interest.
Scoring the Sub-Scales is derived by counting the checkmarks in each column.
To generate a Total Pain Score sum all four Sub-Scale totals.

Comments: _____

Sub-scale Scores:

Facial Expressions	
Activity/Body Movement	
Social/Personality Mood	
Other	
Total Checklist Score	

* "Other" sub-scale includes physiological changes, eating and sleeping changes and vocal behaviours.

This version of the scale does not include the items "sitting and rocking", "quiet/withdrawn", and "vacant blank stare" as these were not found to be useful in discriminating pain from non-pain states.

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Note on Scoring: There is no recommended cut off score at this time. Scores all depend on the person and context (e.g., whether they are assessed over a shift or during a transfer). The authors recommend an individualized approach whereby a baseline series of scores is collected for each resident and then the nurse observes deviations from the score (also examining whether pain treatments result in decline in scores).
Email correspondence from Thomas Hadjistavropoulos May 28, 2007

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Facial Expressions	Present	Activity/Body Movement	Present	Social/Personality/Mood	Present
Grimacing		Decreased activity		Upset	
Sad Look		Refusing medications		Agitated	
Tighter face		Moving slow		Cranky/Irritable	
Dirty look		Impulsive Behaviour (e.g., repetitive movements)		Frustrated	
Change in eyes (squinting, dull, bright, increased movement)		Uncooperative/Resistant to care		Other*	
Frowning		Guarding sore area		Pale Face	
Pain expression		Touching/holding sore area		Flushed, red face	
Grim face		Limping		Teary eyed	
Clenching teeth		Clenched fist		Sweating	
Wincing		Going into foetal position		Shaking/Trembling	
Opening mouth		Stiff/Rigid		Cold & clammy	
Creasing forehead		Social/Personality/Mood		Changes in sleep (please circle):	
Screwing up nose		Physical aggression (e.g., pushing people and/or objects, scratching others, hitting others, striking, kicking)		Decreased sleep or	
Activity/Body Movement		Verbal aggression		Increased sleep during day	
Fidgeting		Not wanting to be touched		Changes in Appetite (please	
Pulling Away		Not allowing people near		Decreased appetite or	
Flinching		Angry/Mad		Increased appetite	
Restless		Throwing things		Screaming/Yelling	
Pacing		Increased confusion		Calling out (i.e. for help)	
Wandering		Anxious		Crying	
Trying to leave				A specific sound or vocalisation	
Refusing to move				For pain 'ow', ouch'	
Thrashing				Moaning and groaning	
				Mumbling	
				Grunting	

