

DOLOPLUS-2 SCALE

BEHAVIOURAL PAIN ASSESSMENT IN THE ELDERLY

NAME :		Christian Name :		Unit :		DATES			
Behavioural Records									
SOMATIC REACTIONS									
1• Somatic complaints	• no complaints	0	0	0	0				
	• complaints expressed upon inquiry only	1	1	1	1				
	• occasional involuntary complaints	2	2	2	2				
	• continuous involuntary complaints	3	3	3	3				
2• Protective body postures adopted at rest	• no protective body posture	0	0	0	0				
	• the patient occasionally avoids certain positions	1	1	1	1				
	• protective postures continuously and effectively sought	2	2	2	2				
	• protective postures continuously sought, without success	3	3	3	3				
3• Protection of sore areas	• no protective action taken	0	0	0	0				
	• protective actions attempted without interfering against any investigation or nursing	1	1	1	1				
	• protective actions against any investigation or nursing	2	2	2	2				
	• protective actions taken at rest, even when not approached	3	3	3	3				
4• Expression	• usual expression	0	0	0	0				
	• expression showing pain when approached	1	1	1	1				
	• expression showing pain even without being approached	2	2	2	2				
	• permanent and unusually blank look (voiceless, staring, looking blank)	3	3	3	3				
5• Sleep pattern	• normal sleep	0	0	0	0				
	• difficult to go to sleep	1	1	1	1				
	• frequent waking (restlessness)	2	2	2	2				
	• insomnia affecting waking times	3	3	3	3				
PSYCHOMOTOR REACTIONS									
6• washing &/or dressing	• usual abilities unaffected	0	0	0	0				
	• usual abilities slightly affected (careful but thorough)	1	1	1	1				
	• usual abilities highly impaired, washing &/or dressing is laborious and incomplete	2	2	2	2				
	• washing &/or dressing rendered impossible as the patient resists any attempt	3	3	3	3				
7• Mobility	• usual abilities & activities remain unaffected	0	0	0	0				
	• usual activities are reduced (the patient avoids certain movements and reduces his/her walking distance)	1	1	1	1				
	• usual activities and abilities reduced (even with help, the patient cuts down on his/her movements)	2	2	2	2				
	• any movement is impossible, the patient resists all persuasion	3	3	3	3				
PSYCHOSOCIAL REACTIONS									
8• Communication	• unchanged	0	0	0	0				
	• heightened (the patient demands attention in an unusual manner)	1	1	1	1				
	• lessened (the patient cuts him/herself off)	2	2	2	2				
	• absence or refusal of any form of communication	3	3	3	3				
9• Social life	• participates normally in every activity (meals, entertainment, therapy workshop)	0	0	0	0				
	• participates in activities when asked to do so only	1	1	1	1				
	• sometimes refuses to participate in any activity	2	2	2	2				
	• refuses to participate in anything	3	3	3	3				
10• Problems of behaviour	• normal behaviour	0	0	0	0				
	• problems of repetitive reactive behaviour	1	1	1	1				
	• problems of permanent reactive behaviour	2	2	2	2				
	• permanent behaviour problems (without any external stimulus)	3	3	3	3				
COPYRIGHT						SCORE			

DOLOPLUS-2 SCALE : LEXICON

Somatic complaints

The patients expresses pain by word, gesture, cries, tears or moans.

Protective body postures adopted at rest

Unusual body positions intended to avoid or relieve pain.

Protection of sore areas

The patient protects one or several areas of his/her body by a defensive attitude or gestures.

Expression

The facial expression appears to express pain (grimaces, drawn, atonic) as does the gaze (fixed gaze, empty gaze, absent, tears).

Investigation

Any investigation whatsoever (approach of a caregiver, mobilization, care procedure, etc.).

Washing/dressing

Pain assessment during washing and/or dressing, alone or with assistance.

Mobility

Evaluation of pain in movement: change of position, transfer, walking alone or with assistance.

Communication

Verbal or non-verbal.

Social life

Meals, events, activities, therapeutic workshops, visits, etc.

Problems of behaviour

Aggressiveness, agitation, confusion, indifference, lapsing, regression, asking for euthanasia, etc.

DOLOPLUS-2 SCALE : INSTRUCTIONS FOR USE

1 • Scale use requires learning

As is the case with any new instrument, it is judicious to test it before circulating it. Scale scoring time decreases with experience (at most a few minutes). Where possible, it is of value to appoint a reference person in a given care structure.

2 • Pluridisciplinary team scoring

Irrespective of the health-care, social-care or home structure, scoring by several caregivers is preferable (physician, nurse, nursing assistant, etc.). At home, the family and other persons can contribute using a liaison notebook, telephone or even a bedside meeting. The scale should be included in the 'care' or 'liaison notebook' file.

3 • Do not score if the item is inappropriate

It is not necessary to have a response for all the items on the scale, particularly given an unknown patient on whom one does not yet have all the data, particularly at psychosocial level. Similarly, in the event of coma, scoring will be mainly based on the somatic items.

4 • Compile score kinetics

Re-assessment should be twice daily until the pain is sedated, then at longer intervals, depending on the situation. Compile score kinetics and show the kinetics on the care chart (like temperature or blood pressure). The scale will thus become an essential argument in the management of the symptom and in treatment initiation.

5 • Do not compare scores on different patients

Pain is a subjective and personal sensation and emotion. It is therefore of no value to compare scores between patients. Only the time course of the scores in a given patient is of interest.

6 • If in doubt, do not hesitate to conduct a test treatment with an appropriate analgesic

It is now accepted that a score greater than or equal to 5/30 is a sign of pain. However, for borderline scores, the patient should be given the benefit of the doubt. If the patient's behavior changes following analgesic administration, pain is indeed involved.

7 • The scale scores pain and not depression, dependence or cognitive functions

Numerous instruments are available for each situation. It is of primary importance to understand that the scale is used to detect changes in behavior related to potential pain. Thus, for items 6 and 7, we are not evaluating dependence or independence but pain.

8 • Do not use the DOLOPLUS 2 scale systematically

When the elderly patient is communicative and cooperative, it is logical to use the self-assessment instruments. When pain is patent, it is more urgent to relieve it than to assess it ... However, if there is the slightest doubt, hetero-assessment will avoid underestimation.

The Doloplus 2

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Tool availability

The tool may be accessed on the website of the Doloplus Group:

<http://www.doloplus.com>