

Pain Assessment in the Cognitively Impaired (PACI)

Description: The PACI is a direct-care provider administered screening tool developed with the aim of assessing “in the moment” pain in long-term care residents unable to communicate their pain, particularly those with palliative care needs. Kaasalainen et al. (2011), stress the importance of the knowledge of caregivers to know the individual varying patterns of each older adult. Additionally, clinical usefulness and feasibility was a high priority in the development of the tool. The American Geriatric Society (2002) guidelines, literature review, and qualitative interviews with direct caregivers served as the foundation for item development. The 7-item tool covers three dimensions of pain expression: facial expression (3 items), verbalizations (2 items), and body movements (2 items), with a dichotomous rating and potential scoring range of 0 (no pain) to 7 (high pain).

Psychometrics: Limited psychometric data is available. Construct validity is supported with tool authors reporting significant differences in scores between activity and rest. When the PACI was compared to another observational pain tool (PACSLAC), the two were correlated at $r=.79$, providing initial support for concurrent validity. Moderate inter-rater reliability scores have been reported with a range of 0.59-.66. No internal consistency data is available.

Languages and Settings: The PACI is available in English; studies have been limited to the Canadian nursing home setting.

Feasibility and Clinical Utility: Because this was a specific focus of the tool developers, the PACI appears to be clinically feasible, requiring minimal training for

direct care providers, although no specific information about training and time to administer or score is provided by the tool authors.

Scoring and Interpretation: Scoring of the PACI is clear (0-7) based on the presence or absence of the indicated behaviors. Authors suggest an interpretation of a score of 0 to represent 'no pain' and a score of 7 to represent 'high pain'. The scoring, though not directly addressed, implies a measure of pain intensity that is not supported in the literature. The authors do acknowledge that intensity scoring is not recommended, and suggest use of the tool to screen for pain, providing a quick assessment that allows for monitoring of individual patterns over time for a single individual.

Summary: This proxy report of pain intensity, even by direct care providers' familiar with the older adult, is not sufficiently supported in the literature. Additionally, concern remains regarding the scope of direct care providers' practice not being extended to assessment skills, thus this tool remains most useful for screening, rather than assessment purposes. Because of limited psychometric testing data information, further testing to assess sensitivity and specificity, as well as responsiveness to treatment effects, is needed. Internal consistency data is also needed. Testing in other cultures and settings would also be valuable. Should these issues be addressed with future revisions, clinical utility of the tool could also be enhanced by improving score interpretation guidelines.

Contact Information for Tool Developer:

Sharon Kaasalainen, PhD, MSc, BScN, RN
Associate Professor
McMaster University
School of Nursing
1280 Main Street West, HSC 3N25F
Hamilton, Ontario L8S 4K1, Canada
905-525-9140 ext 22291
kaasal@mcmaster.ca

References:

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