



Recognising & Assessing **Pain** in Dementia

A practical guide for care
professionals

**At least 1 in 2 people
with dementia live in pain**

1 Why pain assessment matters this World Alzheimer's Day

Assessing pain effectively is fundamental to high-quality dementia care — and widely accepted as a basic human right. For someone living with moderate to severe dementia, the most reliable method of assessment, self-reporting, is often no longer possible. That places the responsibility firmly with care teams to recognise pain through other means.

Dementia itself does not cause pain, but people living with dementia are more susceptible to it because of a higher risk of falls, accidents and injury. When their pain goes unrecognised it is left untreated — slowing recovery, accelerating cognitive decline and driving distressing behavioural and psychological symptoms that affect the person, their family and your staff.

50%

of people with dementia regularly experience pain

90%

experience behavioural & psychological symptoms (BPSD)

~80%

of 180,000 UK antipsychotic prescriptions found inappropriate

2 Why pain so often goes undetected

Three common challenges make pain in dementia easy to miss. Recognising them is the first step to closing the gap.

Subjectivity

Many teams rely on personal knowledge of a resident to gauge pain. That knowledge varies from one staff member to the next — and is stretched further by staff turnover and agency cover — producing inconsistent pain scores and no reliable baseline.

Communication

Effective communication of pain needs someone who can describe their symptoms and someone who can understand them. When dementia impairs a person's ability to communicate, non-verbal indicators become essential.

Documentation

In one study of 169 patients, 29% of pain episodes had no documentation at all, and only 13% recorded information across all four pain-management domains. Without a consistent, auditable trail, effective pain management is almost impossible to sustain.

3 Spotting the signs: a non-verbal pain checklist

When someone cannot tell you they are in pain, their face, body, voice and behaviour often will. Use these non-verbal cues as prompts during everyday care and at every pain assessment.

Face

- ☐ Frowning, grimacing or a frightened expression
- ☐ Rapid blinking or tightly closed eyes
- ☐ Clenched jaw or wrinkled forehead

Body & movement

- ☐ Guarding or bracing a body part
- ☐ Restlessness, rocking or fidgeting
- ☐ Reluctance to move; altered gait or posture

Voice

- ☐ Sighing, moaning or groaning
- ☐ Calling out or noisy breathing
- ☐ Crying or verbal outbursts

Behaviour & routine

- ☐ New or increased agitation or aggression
- ☐ Withdrawal, low mood or resisting care
- ☐ Changes in sleep, appetite or wandering

Tip: A sudden change in behaviour is one of the most reliable signals that something is wrong. Before attributing new agitation to dementia, always ask: **could this be pain?**

4 The hidden cost of missed pain

Inappropriate antipsychotic prescribing

Residents displaying BPSD are commonly prescribed antipsychotics — medicines that carry serious risks, including an increased chance of stroke, and that do not address the root cause of distress. A UK Department of Health study found close to 80% of 180,000 antipsychotic prescriptions for people with dementia were inappropriate. Ruling pain in or out is routinely recommended as a first intervention when addressing BPSD.

Pain and the immune system

Untreated chronic pain triggers a sustained stress response and raised cortisol, which is linked to a decline in immune function. Research from McGill University even found that chronic pain can reprogramme how DNA is marked in immune T-cells. Differentiating pain from behaviour is therefore about far more than comfort.

5 Building consistent practice: the four pain-management domains

Quality documentation underpins evidence-based pain management. Aim to demonstrate all four domains for every episode of pain:

- 1 **Identification** — notice and flag that pain may be present.
- 2 **Assessment** — measure it using a consistent, validated tool.
- 3 **Intervention** — act, whether through medication or therapy-based approaches.
- 4 **Evaluation** — reassess to confirm the intervention worked, and adjust.

Recording all four consistently removes reliance on individual staff knowledge, so every resident receives the same standard of care regardless of who is on shift.

6 How digital tools strengthen dementia care

Paper-based assessments take time, are easily under-used and produce inconsistent results. Moving to a digital, point-of-care model helps care teams to:

- ✓ Capture objective, non-verbal indicators of pain at the bedside in moments
- ✓ Reduce subjectivity and create a consistent baseline for each resident
- ✓ Build an auditable, chronological record of the pain burden across the home
- ✓ Share insight instantly with GPs, allied health professionals and families
- ✓ Make regular pain assessment a realistic, everyday part of care

"Since we introduced PainChek® as a standard pain assessment tool for cognitively impaired residents in our facility, we have had a 72% increase in the number of pain assessments completed. This has translated into more pain interventions applied, including PRN medications and therapy-based solutions."

— Matt Kowald, General Manager, Barossa Village



About PainChek® · Ready to close the pain-assessment gap?

PainChek® is the world's first intelligent pain assessment tool for people living with dementia. It uses AI and facial analysis to identify involuntary micro-facial expressions associated with pain, combined with behaviours, vocalisations and movement, to deliver fast, reliable pain scores at the point of care. PainChek® holds CE-mark clearance as a medical device in the UK and Europe and TGA approval in Australia.

This World Alzheimer's Day, take the first step towards more consistent, evidence-based pain care for your residents.

Book a demo or find out more:

Web: www.painchek.com | Email: info@painchek.com | UK: 0333 577 3397

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