SCOL / CARE360

An interdisciplinary model of long-term care



Comprehensive geriatric assessment and individualised care

Stołeczne Centrum Opiekuńczo-Lecznicze, Warsaw

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SCOL: the care environment



Long-term medical and nursing care



Rehabilitation and support in daily life

Clinical complexity in long-term care

Multimorbidity	Interacting conditions and competing treatment priorities
Functional dependence	Assistance with mobility, personal care and daily activities
Cognitive impairment	Communication barriers and unrecognised symptoms
Medication burden	Polypharmacy and susceptibility to adverse drug effects

Neumann-Podczaska A et al. Gerontol Pol. 2025;33:276–282. doi:10.53139/GP.20253335.

An integrated model of care

Comprehensive assessment	Clinical, functional, psychological and social needs
Joint clinical decisions	Professional perspectives integrated around the patient
Individualised care plan	Explicit goals, agreed interventions and responsibilities
Reassessment	Review of implementation, response and remaining needs

Neumann-Podczaska A et al. Gerontol Pol. 2025;33:276–282. doi:10.53139/GP.20253335.

Comprehensive geriatric assessment



A shared framework

Clinical findings linked with everyday function and individual priorities

Assessment informs one coordinated care plan

Neumann-Podczaska A et al. Gerontol Pol. 2025;33:276–282. doi:10.53139/GP.20253335.

The interdisciplinary team



Physician and nurse

Clinical pharmacist

Psychologist

Physiotherapist

Occupational and speech therapists

Dietitian and social worker

Professional perspectives inform one individualised care plan.

Neumann-Podczaska A et al. Gerontol Pol. 2025;33:276–282. doi:10.53139/GP.20253335.

Pain and behavioural symptoms

Symptom recognition	Facial expression, vocalisation and movement during care
Clinical interpretation	Pain considered alongside other causes of distress
Structured assessment	Observational tools when reliable self-report is unavailable
Treatment evaluation	Comfort and behaviour reassessed after intervention

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Abbey Pain Scale: observational assessment

Six domains, each scored 0–3. Total score: 0–18.

Observation domain	Examples
Vocalisation	Whimpering, groaning or crying
Facial expression	Grimacing, tension or a frightened expression
Body language	Restlessness or guarding a painful area
Behavioural change	Refusing food, increased confusion or altered routines
Physiological changes	Changes in pulse, blood pressure, temperature or perspiration
Physical changes	Skin damage, pressure injuries, contractures or arthritis

0–2: no pain **3–7: mild** **8–13: moderate** **14–18: severe**

Abbey J et al. Int J Palliat Nurs. 2004;10:6–13. DOI: 10.12968/ijpn.2004.10.1.12013.

Cohen–Mansfield Agitation Inventory (CMAI)

29 behaviours. Frequency over the previous two weeks. Total: 29–203.

1. Pacing / aimless wandering
2. Inappropriate dressing / disrobing
3. Spitting
4. Cursing / verbal aggression
5. Repeated requests for attention / help
6. Repetitive sentences or questions
7. Hitting, including self
8. Kicking
9. Grabbing people
10. Pushing
11. Throwing objects
12. Making strange noises
13. Screaming
14. Biting
15. Scratching
16. Trying to get to a different place
17. Intentional falling
18. Complaining
19. Negativism
20. Eating / drinking inappropriate substances
21. Hurting self or others
22. Handling objects inappropriately
23. Hiding objects
24. Hoarding objects
25. Destroying property
26. Repetitive mannerisms
27. Verbal sexual advances
28. Physical sexual advances
29. General restlessness

Frequency: 1 never, 2 <weekly, 3 once/twice weekly, 4 several times weekly
5 once/twice daily, 6 several times daily, 7 several times hourly

Cohen-Mansfield J. Int Psychogeriatr. 1997;9(S1):173–178. DOI: 10.1017/S1041610297004006.

Pain and agitation: the Abbey–CMAI relationship



Open Access Full Text Article ORIGINAL RESEARCH

Pain as a challenge in nursing home residents with behavioral and psychological symptoms of dementia

This article was published in the following Dove Press journal:
Clinical Interventions in Aging

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Introduction: In patients with dementia, observational scales are recommended for use in the assessment of pain. Unfortunately, their application is rare, and as a consequence pain is frequently underdiagnosed and undertreated in these types of subjects. Thus, the aim of the study was to assess analgesic treatment in nursing home residents with cognitive impairment and to delineate the relationship between pain and behavioral and psychological symptoms of dementia.

Patients and methods: The research was conducted in 2 nursing home facilities in Wielkopolska, Poland. The analyzed group consisted of 96 residents (78 female) with moderate and severe cognitive impairment in whom pain was assessed with the Abbey Pain Scale (APS) and agitation with the Cohen–Mansfield Agitation Inventory (CMAI). Thereafter, medical files related to drug prescriptions were analyzed.

Results: Analgesics were consumed by 33 individuals (34%); 24 (25%) received regular pain treatment and 7 individuals (7%) – as when needed pain treatment. A relationship was found between the APS and CMAI (r=0.45, p<0.0001). Subjects with a higher CMAI received sedative drugs more frequently (p<0.001), and despite having a higher APS (p=0.001), this did not correlate with higher analgesia.

Conclusion: Our study suggests that pain can be an important underlying cause of behavioral disturbances in older subjects with dementia. In order to reduce their frequency and to avoid excessive usage of sedatives, proper pain assessment and management are essential.

Keywords: pain, analgesics, nursing home residents, older individuals, Abbey Pain Scale, CMAI

Introduction

Dementia affects approximately 24.3 million people worldwide and is expected to increase to 115 million by 2050 as the population of older individuals grows.[1] Approximately one-third of people with dementia are nursing home residents (NHR).

Advanced age correlates not only with the increased prevalence of dementia, but also as a result of other comorbidities leading to pain.[2] The data regarding the pain frequency among NHR with dementia are unclear, but it is estimated that 40%–60% of them suffer daily from moderate to severe pain.[3–5]

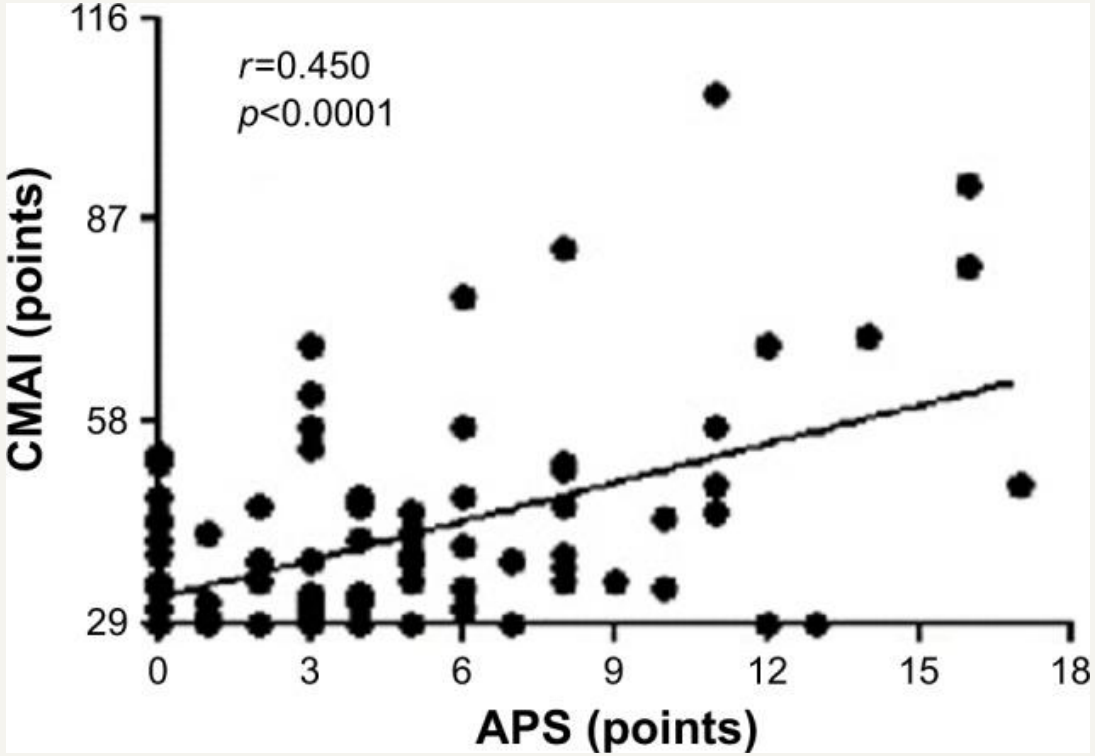
Dementia is frequently accompanied by behavioral and psychological symptoms of dementia (BPSD) defined as signs and symptoms of disturbed perception, thought content, mood, or behavior.[6] In patients with BPSD, due to language, memory, and abstract-thinking deficits, pain self-report capacity is substantially decreased or even absent. In such patients, observational pain scales need to be used.[7] However, their application may be a challenge as the estimation of pain depends not only on observation and communication with the patient but also on the knowledge of caregivers and medical staff and their ability to make an accurate diagnosis.[8] As a result, pain in elderly subjects with dementia is frequently underdiagnosed, and thus undertreated.[4]

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96 residents r = 0.45 p < 0.0001



Higher pain scores were associated with greater agitation.

Nowak T, Neumann-Podczaska A et al. Clin Interv Aging. 2018;13:1045–1051. DOI: 10.2147/CIA.S157246.

Individualised medicines optimisation

Indication and benefit	Ongoing need, treatment goals and expected clinical value
Safety and burden	Adverse effects, interactions and cumulative medication load
Treatment adjustment	Planned deprescribing or correction of undertreatment
Follow-up	Clinical response, tolerability and functional consequences

Neumann-Podczaska A et al. Gerontol Pol. 2025;33:276–282. doi:10.53139/GP.20253335.

Case 1: two antipsychotics

84 years old

Parkinson's disease
and mild dementia

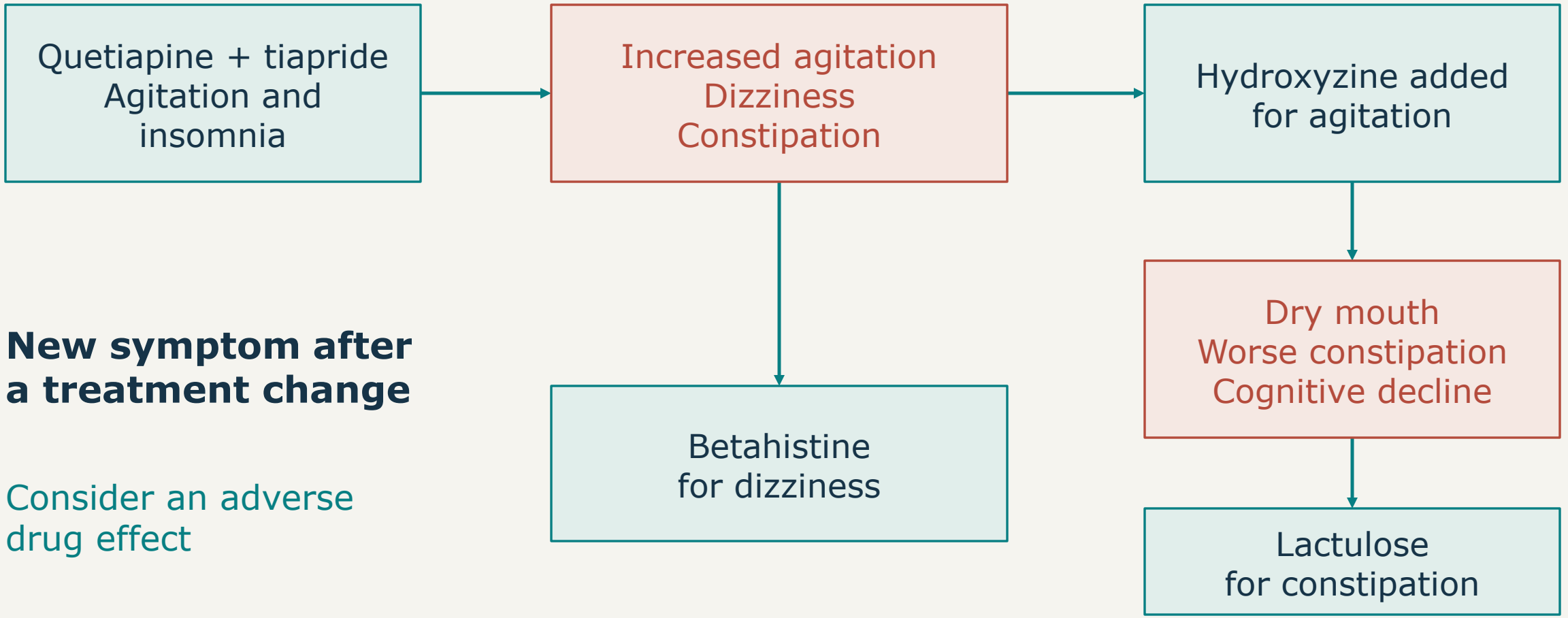
16 medicines

Quetiapine + tiapride
Hydroxyzine added later



Lan et al. Geriatr Gerontol Int. 2025. DOI: 10.1111/ggi.70118.

An antipsychotic prescribing cascade



New symptom after a treatment change

Consider an adverse drug effect

Lan et al., 2025. DOI: 10.1111/ggi.70118.

Outcomes after interdisciplinary review

Team	Physician, nurse, pharmacist and psychiatrist
Treatment review	Withdrawal of medicines without benefit or indication
Observed improvement	Orientation, mood and participation in daily activities
Symptom reduction	Less agitation and constipation, resolution of dizziness

Lan et al., 2025. DOI: 10.1111/ggi.70118.

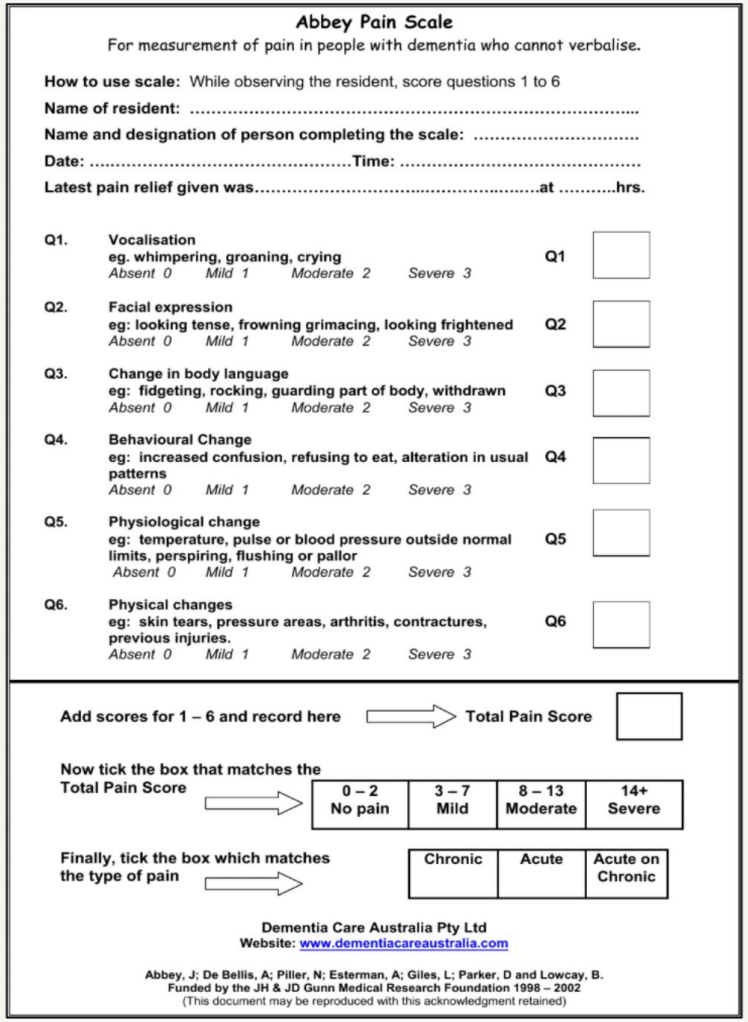
Case 2: vocalisation as a sign of pain

72 years old

Stroke, aphasia and immobility
Rheumatoid arthritis

Vocalisation, facial grimacing and resistance during care

Abbey score: 14
Severe pain range



Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident: .....

Name and designation of person completing the scale: .....

Date: .....**Time:** .....

Latest pain relief given was.....**at** .....**hrs.**

Q1.	**Vocalisation** **eg. whimpering, groaning, crying** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q1	
Q2.	**Facial expression** **eg: looking tense, frowning grimacing, looking frightened** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q2	
Q3.	**Change in body language** **eg: fidgeting, rocking, guarding part of body, withdrawn** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q3	
Q4.	**Behavioural Change** **eg: increased confusion, refusing to eat, alteration in usual patterns** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q4	
Q5.	**Physiological change** **eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q5	
Q6.	**Physical changes** **eg: skin tears, pressure areas, arthritis, contractures, previous injuries.** *Absent 0 Mild 1 Moderate 2 Severe 3*	Q6	

Add scores for 1 – 6 and record here → **Total Pain Score** ☐

Now tick the box that matches the Total Pain Score →

0 – 2	3 – 7	8 – 13	14+
No pain	Mild	Moderate	Severe

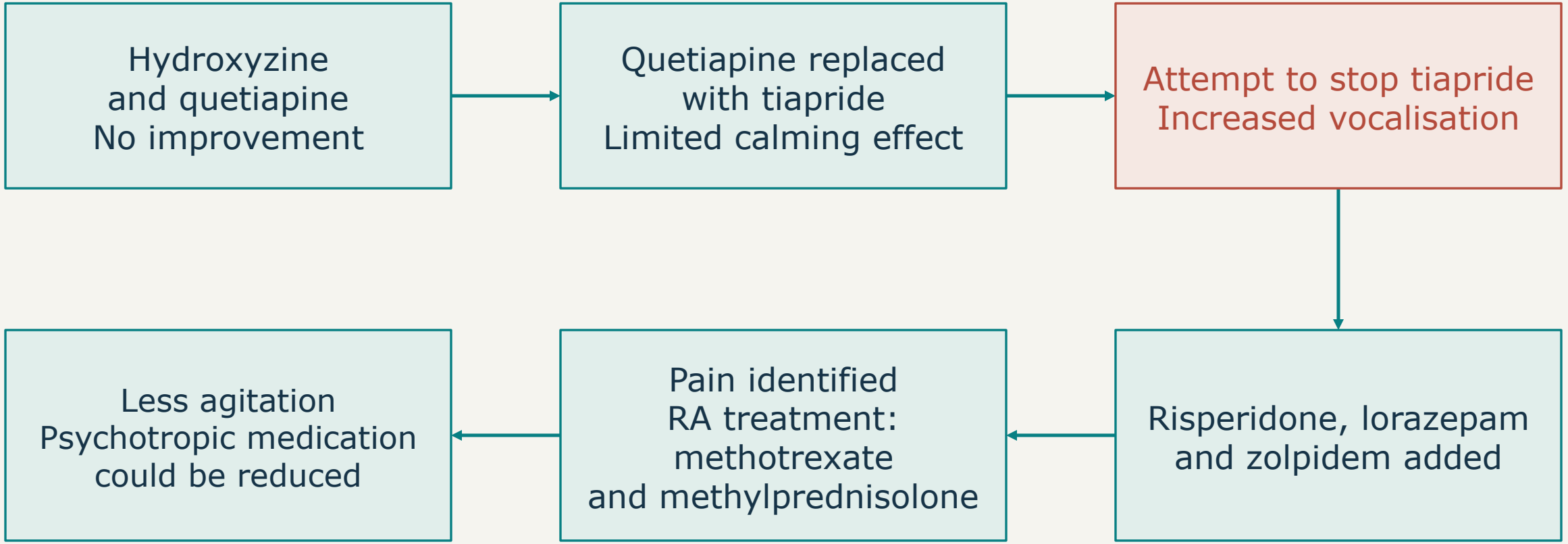
Finally, tick the box which matches the type of pain →

Chronic	Acute	Acute on Chronic

Dementia Care Australia Pty Ltd
Website: www.dementiacareaustralia.com

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
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Unrecognised pain and treatment escalation



An underlying physical cause requires targeted treatment

Treating the cause enabled deprescribing

Pain assessment	Identification of a physical cause of distress
RA treatment	Reduced agitation after treatment of the underlying condition
Psychotropic medication reduction	Risperidone stopped, other medicines reduced
Daily function	Oral feeding and greater participation in rehabilitation

Monitoring patient-centred outcomes

Comfort	Pain, distress, sleep and tolerance of personal care
Function	Mobility, daily activities and participation
Treatment safety	Sedation, falls and other suspected adverse effects
Care-plan review	Implementation barriers and the need to adjust interventions

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International recognition in Cannes

Jury’s Special Mention

SilverEco & Ageing Well International Awards 2026



SCOL / CARE360

Prevention, Health & Longevity

Cannes, France
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An interdisciplinary model based on comprehensive geriatric assessment



CARE360 at SCOL

Comprehensive assessment

Interdisciplinary collaboration

Individualised treatment and care

Continuous review

Thank you

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