

Pain

Standardised care process



Objective

To promote an evidence-based approach to the assessment and management of pain experienced by older people who live in a residential aged care setting.

Why the identification and management of pain is important

Access to pain relief is a basic human right (Brennan et al. 2007). It is estimated that 27–80 per cent of people in residential care experience persistent pain (White & Katz 2012). Older age and the presence of cognitive impairment increases the risk of pain being under recognised, under assessed and undertreated (White & Katz 2012; Horgas et al. 2016).

‘The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment’ (Merskey & Bogduk 1994, p. 210).

Definitions

Pain: ‘an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage’ (Merskey & Bogduk 1994, p. 210).

Persistent pain: ‘pain that persists beyond the time expected for healing to occur’ (White & Katz 2012).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), pharmacist, residents and/or family/carers.

Acknowledgement

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2017.



Brief standardised care process

Recognition and assessment

- Identify pain through direct enquiry and observation.
- Assess acute pain in residents to locate the source of the pain and to provide symptomatic relief.
- Assess persistent pain across the following domains:
 - pain history and characteristics
 - physical, functional and psychosocial
 - effectiveness of current pharmacological and non-pharmacological pain interventions.
- Validated pain tools/scales should be used.

Interventions

- Acute pain:
 - Manage underlying cause
 - Relieve symptoms
- Persistent pain:
 - Pharmacological management
 - Non-pharmacological management
 - Physical therapies
- Document the resident's responses to pain management interventions.

Referral

- RN
- GP
- Physiotherapist and occupational therapist
- Pain management specialist or clinic
- Psychologist
- Complementary and alternative medicine (CAM) practitioners
- Interpreter for residents who speak a language other than English
- Local palliative care services

Evaluation and reassessment

- Monitor pharmacological treatment effects on pain within one hour of administration of medication and at least every four hours thereafter.
- Regularly review and assess the therapeutic benefit of the interventions used.
- Monitor for any interactions or adverse effects.
- Monitor, review and adjust the interventions until the resident's pain is appropriately managed.
- Maintain a vigilance for signs and symptoms that indicate the presence of pain.

Resident involvement

- Identify the resident's goals for pain management.
- Determine whether the current level of pain relief is consistent with the resident's goals.
- Support self-management.
- Educate the resident and their family.

Staff knowledge and education

- Educate staff to:
 - recognise that all residents, including those with dementia, may have pain
 - recognise that residents may use various descriptors to communicate their experience of pain
 - understand the non-verbal signs of pain in residents with dementia
 - use non-pharmacological pain management strategies
 - use analgesic medication prophylactically
 - understand the importance of assessing pain on movement.
- Have experienced, skilled and knowledgeable clinicians responsible for the pain management portfolio.
- Use the educational resources available from external health and palliative care organisations.



Full standardised care process

Recognition

Pain identification through direct enquiry about the presence of pain should occur:

- on admission
- when the resident's condition significantly changes
- any time pain is suspected
- at least every three months
- during scheduled assessments/resident of the day.

Residents should be observed for non-verbal and behavioural signs of pain.

Assessment

Acute pain:

Acute pain of recent onset is often related to a disease or injury. Undertake a rapid pain assessment when the resident presents with acute pain or distress of moderate to severe intensity. The assessment should include the pain's location, intensity, duration, quality and onset.

Persistent pain:

The assessment of persistent pain requires a comprehensive approach involving the resident, their family/carer and the multidisciplinary team. Assess pain across medical, functional, social, attitudinal, cognitive, mood and quality-of-life domains.

Assessment approaches that include both self-report and observational measures should be used where possible.

Self-report:

- Determine the resident's cognitive, sensory and communication ability to evaluate and convey their pain.
- Valid self-reports of pain can be provided by residents with mild to moderate dementia. Using self-report with an observational tool may be beneficial.
- Self-report assessment tools should be offered in an accessible format (simplified language, large fonts, written and oral instructions, language other than English) and administered using clear explanations.

- Support the resident's communication ability with sensory aids and a quiet, distraction-free environment.

Residents who are unable to verbally self-report:

A combination of the following should be used to identify pain in residents who are unable to verbally report their pain:

- observational pain assessment, which includes:
 - interpretation of pain behaviours (including but not limited to agitation, resisting care, aggression, negative vocalisations and facial expression)
 - changes in body language (guarding, limping).
- presence of pathology that may be a cause of pain (pressure injury, osteoarthritis)
- pain history from family or carers
- response to pain relieving interventions (pharmacological, non-pharmacological and physical therapies).

Pain measurement tools/scales:

- Using a multidimensional pain assessment tool such as the Modified Residents Verbal Brief Pain Inventory (M-RVBPI) will assist in the initial pain assessment.
- Once a suitable pain measurement tool has been identified, recurrent assessments should be undertaken using the same instrument to evaluate the effects of treatment.
- Pain should be assessed at rest and on movement.

Suitable tools/scales include but are not limited to:

- *Pain measurement tool (self-report)*: Numerical or visual analogue scales. Vertical verbal descriptor scales or faces scales are recommended for residents with mild to moderate cognitive or communication impairment.
- *Pain measurement tools (observational)*: Abbey Pain Scale, Pain Assessment in Advanced Dementia (PAINAD), Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) and Doloplus 2.

Review history of:

- pain onset: event or circumstances (prior injury, illness, surgery) resulting in the onset of pain
- general medical history and evaluation of comorbid conditions precipitating factors.

The assessment of the resident's pain characteristics should include:

- pain quality – the words used by the resident to describe the pain (such as 'aching' or 'sore')
- pain severity/intensity – use a standardised intensity rating scale (see tools/scales)
- duration/frequency and fluctuations throughout the day
- pattern – continuous, intermittent, factors that aggravate and relieve the pain
- identification of the sites of pain – use a diagram/pain map where possible
- radiation/referral
- onset (when the problem started).

The physical assessment for pain should include:

- signs of inflammation (swelling, heat, redness in affected area)
- the report of pain or the behavioural response caused by touch, pressure, movement (active and passive range of motion), weight bearing or other body functions (such as breathing and swallowing)
- abnormal sensations including numbness, pain from a non-painful stimulation, heightened sensitivity to pain and hypersensitivity to sensory stimuli
- laboratory/diagnostic tests where indicated
- cognitive status (severe pain can affect cognition and memory).

The functional assessment for pain should include its impact on:

- activities of daily living (ADLs) and functional ability
- sleep and appetite.

The psychosocial assessment should include asking the resident about:

- their concerns, worries and beliefs about the pain
- how they respond to the pain
- pain-related changes to their mental/mood state (depression) (use a validated tool to assess the symptoms of depression)
- emotional responses to pain (such as fear/anxiety, acceptance)

- coping strategies (passive or active) and the resident's level of perceived control over the pain
- the resident's knowledge and level of understanding about pain and pain management
- expectations of treatment
- the impact on family and other supports
- the impact on social participation
- the impact on pleasurable activities
- the impact on quality of life.

Evaluate the effectiveness of the resident's current treatments for pain by reviewing:

- their medication history (including prescription, over-the-counter, complementary and alternative medicines) and allergies
- the side effect profile of medications and any drug interactions
- the use of alcohol, medicines and illicit drugs to manage the pain
- observational pain charts and verbal pain scores
- what works to relieve the pain and what doesn't.

Interventions

Acute pain:

- There is an expectation that acute pain of recent onset will resolve with healing or with treatment of the underlying cause.
- Symptomatic relief should be offered until the acute episode has resolved.

Persistent pain:

The plan of care for residents experiencing persistent pain should be comprehensive, individualised and developed in partnership with the resident, family or substitute decision-maker and multidisciplinary team. It should include the goals of pain management and include the interventions for symptoms associated with pain (such as depression, insomnia and constipation). Interventions can be used in combination.

Pharmacological:

- The side effects, drug interactions and contraindications of pain-relieving medicines should be anticipated, treated or avoided.
- Analgesia should be administered on a regular basis ('around the clock') to maintain therapeutic levels.

- As needed (PRN) short-acting analgesia given prior to an activity can be effective at reducing predictable (incident) pain. Administer 30 minutes prior to the activity.
- Medication type, dose, route of administration, monitoring and any adjustment should be carefully managed according to the pain diagnosis and severity until the goals of pain management are achieved.
- Consider an analgesic trial when the presence of pain remains unclear and a non-communicative resident continues to present with pain behaviours or responsive behaviours.

Non-pharmacological interventions include:

Note: Evidence for the use of the following strategies is limited.

- reassurance and education
- application of superficial heat/cold (to be used with caution)
- massage
- relaxation and meditation techniques
- transcutaneous electrical nerve stimulation (TENS) in residents who can provide reliable feedback
- percutaneous electrical nerve stimulation (PENS)
- cognitive behavioural therapy
- acceptance and commitment therapy (ACT)
- mindfulness
- acupuncture
- reflexology
- other complementary and alternative medicine (CAM) therapies.

Physical therapies:

The prescription of physical therapy should be selected according to the resident's cognitive, communicative and physical abilities and include:

- exercise (prescribed and supervised) – strengthening, stretching and balance, hydrotherapy, functional restoration and isotonic exercises
- appropriate manual handling equipment and techniques to reduce pain on movement.

Always document the resident's response to pain management interventions.

Referral

- RN
- GP
- Physiotherapist
- Occupational therapist
- Pain management specialist or clinic
- Psychologist
- CAM practitioners
- Interpreter when assessing residents who speak a language other than English
- Local palliative care services for residents requiring palliative care

If pain is due to a serious injury or disease, it may not be possible to manage this in the residential care environment.

Evaluation and reassessment

- Monitor treatment effects on pain within one hour of administering medication, and at least every four hours thereafter.
- Regularly review and assess the therapeutic benefit of interventions.
- Monitor for any interactions or adverse effects such as opioid-induced constipation, drug-induced cognitive impairment and falls.
- Continue monitoring, reviewing and adjusting interventions until the resident's pain is appropriately managed.
- Ensure staff vigilance in recognising signs and symptoms that indicate the presence of pain, especially on movement, during daily activities. Document accordingly.

Resident involvement

- Identify the goals for pain management with the resident and/or family.
- Determine whether the current level of pain relief is consistent with the resident's goals.
- Support self-management. Provide self-help resources, pain management strategies and address concerns.
- Educate residents/families about the nature of an individual's pain, the use of pain assessment tools, medication use, non-pharmacological pain management strategies and the benefits of exercise. Suitable written material should be used.
- Educate families to recognise and report pain when visiting a relative.

Staff knowledge and education

- Educate staff to:
 - recognise that all residents, including those with dementia, may have pain
 - recognise that residents may use various descriptors ('sore', 'aching') to communicate their experience of pain
 - understand the non-verbal signs of pain in residents with dementia
 - use non-pharmacological pain management strategies
 - use analgesic medication prophylactically
 - understand the importance of assessing pain on movement.
- Encourage clinicians with advanced skills, knowledge and experience to be responsible for a pain management portfolio.
- Use the educational resources available from external health services, community palliative care, Program of Experience in the Palliative Approach (PEPA) and Palliative Care Regional consortia <<http://www.pallcarevic.asn.au/palliative-care-regional-consortia/>>.



Evidence base for this standardised care process

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Important note: This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law, the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, March 2018. (1802012)

ISBN 978-1-76069-292-6 (pdf/online)

Available from the department's website at <www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes>.