



PREVALENCE

Pain is reported to be twice as prevalent in the elderly as in younger individuals. In the long-term care setting, prevalence can be as high as 85%. According to the American Geriatrics Society (AGS) Panel on Chronic Pain in Older Persons (1998), chronic pain in the long-term care setting is generally under-recognized and under-treated.

DEFINITION

The International Association for the Study of Pain states that pain is “an unpleasant sensory and emotional experience. A simpler definition might be, pain is whatever the person says it is, existing whenever they say it does. Pain includes a variety of physiological, emotional and sensory symptoms such as:

- Aching
- Throbbing
- Burning
- Numbness
- Squeezing
- Pressure
- Cramping
- Tightness

These sensations may vary in intensity, severity, source and management.

BARRIERS AND MISCONCEPTIONS REGARDING RECOGNITION OF PAIN

Clinical practice guidelines for “Chronic Pain Management in the Long-Term Care Setting” from the American Medical Directors Association (AMDA), identified barriers regarding the recognition of chronic pain in the long-term care setting:

- Co-existing illnesses, multiple co-morbidities and medication use may all reduce the resident’s ability to interpret or report pain
- Cognitive impairment and communication barriers (language or speech) hinder a resident’s ability to report pain or respond to caregiver’s questions regarding pain
- Cultural/social bias may hinder resident’s report of pain and acceptance of treatment for pain
- Elderly may not show typical signs and symptoms of pain
- Staff may not have knowledge of or be skilled in assessing pain or at using valid tools available to screen for pain
- System barriers may result in a system that fails to give priority to the recognition, assessment and treatment of pain. System barriers may include: high turnover of staff, poorly functioning care teams, lack of organizational commitment to pain management, physician reluctance to use opioids and fear of regulatory scrutiny.



**MISCONCEPTIONS
ABOUT CHRONIC
PAIN IN THE
ELDERLY**

- It is a sign of personal weakness to acknowledge chronic pain
- Chronic pain is a punishment for past actions
- Chronic pain means death is near
- Chronic pain always indicates the presence of a serious illness
- Acknowledging pain will lead to a loss of independence
- The elderly, especially the cognitively impaired, have a higher tolerance for pain
- The elderly and the cognitively impaired cannot accurately self-report pain
- Residents in long-term care facilities say they are in pain in order to get attention from staff
- Elderly residents are likely to become addicted to pain medication
- Chronic pain is an inevitable consequence of aging

**FURTHER
READING AND
WEB RESOURCES**

A more detailed overview of pain can be obtained by contacting your state Quality Improvement Organization (QIO). Last accessed 11/3/2004
http://www.ahqa.org/pub/connections/162_694_2450.cfm
American Geriatrics Society, Clinical Practice Guidelines. The Management of Chronic Pain in Older Persons: AGS Panel on Chronic Pain in Older Persons. *JAGS* 1998; 46: 635-651.

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Quality Measures Resource Manual, January 2004, Version 4.0, 6E: 1. Last accessed 11/3/2004
<http://www.medqic.org/content/nationalpriorities/nursinghome/nhMeasures.jsp?topicID=413>

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<http://www.cms.hhs.gov/medicaid/mds20/raich3.pdf>



Nursing Home Quality Initiative

FAST FACTS: PAIN Screening

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WHAT IS SCREENING?

A question or test to determine if a person may or may not need further evaluation for a problem or condition. If the result of the screening is positive, it should trigger a comprehensive evaluation of a resident's problem or condition. If the result is negative, the facility should conduct periodic re-screening.

KEY STEPS IN SCREENING

The following are specific changes you can make in your facility regarding screening for pain, that will improve overall pain management:

- Design facility admission/readmission tools to include question(s) of whether or not the resident has any pain.
- Standardize the screening process for pain (i.e. add a screening tool to admission/readmission form, institute pain check as 5th vital sign)
- Institute pain screening tools appropriate for cognitively impaired residents.
- Designate responsibility and accountability to specific staff for screening of pain at admission and periodically thereafter as part of their routine interaction with the resident.
- Promote pain as the Fifth vital sign among all staff. This is not mean that you record pain every time you record vital signs. Rather, you consider pain as important as vital signs, therefore you screen residents for pain whenever you interact or assess a resident. Assign accountability to one staff nurse for monitoring whether pain is evaluated once identified on screening.
- Educate all staff (e.g. CNAs and Nurses) about pain symptoms in the elderly to address pre-existing attitudes about pain, knowledge deficits as well as manifestation of pain in the cognitively impaired.
- Involve resident and family in the pain management process, telling them what they should expect regarding pain management, and their role in working with your staff to assure appropriate identification and management of pain.



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<http://www.cms.hhs.gov/medicaid/mds20/raich3.pdf>

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FAST FACTS: PAIN Evaluation

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**FACILITY
COMMITMENT**

Many factors make pain management in the long-term care setting challenging. Institutional commitment is essential to overcoming these barriers. The leadership of the organization must ensure that a commitment to resident comfort permeates all aspects of the facility's operation.

**KEY STEPS IN
EVALUATION**

- Determine when and how pain evaluations will be performed based on when – i.e. after a screening a resident indicates they have pain.
- Use standardized evaluation tools including pain-rating scales to evaluate resident's complaints of pain found on screening.
- Develop a procedure for incorporating evaluation data into the resident care plan.
- Determine a systematic process to ensure comprehensive re-evaluation of pain are performed when residents (1) have new onset of pain; (2) are new to your facility; (3) have significant change in pattern of pain (i.e. severity, description, location or frequency); (4) are reviewed quarterly with the MDS.
- Periodically audit how well the staff is conducting comprehensive pain evaluations and provide feedback to staff on their performance.

**COMPREHENSIVE
PAIN
EVALUATION**

According to the American Geriatrics Society (AGS) clinical practice guidelines for "The Management of Persistent Pain in Older Adults" (1998), a comprehensive pain evaluation should include the following:

- Intensity
- Character
- Frequency
- Location
- Duration
- Aggravating and alleviating factors
- Medical history
- Thorough analgesic medication history and side effects (if any)
- Activity of daily living performance
- Psychosocial function

A quantitative evaluation of pain should also be recorded by the use of a standard pain scale. Residents with cognitive, language or sensory impairments should be evaluated with scales that are tailored for their needs and disabilities, e.g. numerical pain (0-10), visual pain (pain thermometer and Faces Scale) and verbal descriptor scales.



**NURSING
IMPLICATIONS**

Due to the high number of residents in long-term care who are cognitively impaired, staff should be trained to observe residents for non-specific signs and symptoms that suggest the presence of pain:

- Frowning
- Grimacing
- Fearful facial expression
- Grinding of teeth
- Moaning
- Groaning
- Whimpering
- Crying
- Bracing
- Guarding
- Rubbing a body part
- Fidgeting
- Striking out
- Eating/Sleeping Poorly
- Change in gait
- Change in behavior
- Inability to participate in ADLs

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Nursing Home Quality Initiative

FAST FACTS: PAIN Treatment

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TREATMENT OF PAIN

There is a wide range of pharmacologic, physical and behavioral treatments related to the differing etiologies of pain. The following information is an abbreviated overview of some strategies for pain management in the older adult.

PHARMACOLOGIC AND COMPLEMENTARY APPROACHES

Pharmacologic treatment – this involves the use of analgesic drugs. Dosing for residents requires careful adjustments to optimize pain relief while monitoring and managing side effects. Timing of medication is important. For continuous pain, medications are best given on a regular basis. Additional doses may be required before participation in activities that are known to exacerbate pain (e.g. PT), or may be required for breakthrough pain.

Complementary therapies – usually used in conjunction with medication. The use of these therapies may decrease the need for pain-reducing drugs, but should not be used as substitutes for medication when medication is warranted. Some complementary therapies include:

- Physical modalities – e.g. cutaneous stimulation with heat and/or cold, Transcutaneous Electrical Nerve Stimulation (TENS)
- Physical/Occupational Exercise Therapy – this strengthens weak muscles, mobilizes stiff joints, helps restore coordination and balance, and enhances resident’s comfort. Positioning using braces, splints, wedges, seating systems, etc. to relieve compression or traction of painful and/or inflamed tissue, is another method to promote comfort and to prevent or relieve pain.
- Psychosocial/Spiritual Interventions – focusing on perception and thought, cognitive techniques are designed to influence how one interprets events and bodily sensations. Relaxation and guided imagery can be used to achieve a state of mental and physical relaxation. Deep breathing exercises, aroma therapy and music may also be used to aid relaxation therapies. Pastoral counseling and prayer can also be helpful especially as pain may raise issues of spirituality for the resident and family.



IMPLEMENTING PHARMACOLOGIC AND NON-PHARMACOLOGIC TREATMENTS

- Prescribe pain medications on a regular schedule (vs. PRN basis) for individuals with daily pain. Educate nurses and physicians regarding good pain management. Be sure everyone is aware of the pain management guidelines adopted by your facility (e.g. AGS, AMDA)
- Adjust pain medication frequency (if pain reoccurs before next scheduled pain medication) and dose (if pain is not relieved by current dose)
- Use WHO Step ladder –educate staff on the algorithm and analgesic conversion chart.
- Address potential side effects from pain medications (e.g. constipation) by having a standing order at the time of initiation of opiates.
- Get medical directors involved to speak with recalcitrant physicians.
- Have physicians consider adjuvant medications for certain types of pain (e.g. tricyclics for neuropathic pain). Find local experts to consult on difficulty cases (e.g. hospice)
- Incorporate non-pharmacologic approaches into pain management (e.g. relaxation, hot or cold packs, acupuncture) by having the nurse perform a one-minute non-pharmacologic intervention with each breakthrough dose. Other staff can be trained in these interventions as well.
- Identify a pain champion to follow up one-on-one with staff who have questions about pain management or need just-in-time training.

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American Medical Directors Association. Chronic Pain Management in the Long Term Care Setting Clinical Practice Guideline. Columbia, MA: AMDA 1999. Available online: www.amda.com.

WHO Analgesic Ladder –
<http://www.chcr.brown.edu/commstate/PDF/FASTFACTS3.pdf>

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