

Pain Assessment and Management in Residential Care **Minimum Standards**

Kathleen Downes, RN, BSN, MS(N)
Educator, Residential Practice Team
Vancouver Community, Vancouver Coastal Health

Vicky Bach, RN, BScN, MSN
Clinical Nurse Specialist
Residential Contracts & Services
Fraser Health

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Residential Services Manager, Vancouver Coastal Health

Bruce Kennedy

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Michael McBryde

Medical Director, Residential Services, Fraser Health

Michelle Merkel

Consultant, Quality Improvement & Patient Safety, Residential Services, Fraser Health

Cindy Robertson

Consultant, Quality Improvement & Patient Safety, Residential Services, Fraser Health

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Introduction

The residential care population frequently experiences increased frailty and multiple health and disability problems. Pain can be linked directly to many of these chronic conditions. Studies have shown that up to 80% of the institutionalized elderly has substantial pain that is under-treated (Horgas & Elliott, 2004; Alexander et al., 2005; AGS, 2002; Stolee et al., 2005; Won et al., 2004). Fox et al. (1999) report that 49%-83% of residents experience pain, while only 27% to 44% receive analgesics.

The International Association for the Study of Pain defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage or both” (www.iasp-pain.org). Margo McCaffery’s (1999) definition of pain is that it is “whatever the experiencing person says it is, existing whenever he says it does” (p. 17). Both of these definitions presuppose that the person can communicate the existence and effects of pain.

A high prevalence of dementia or other cognitive impairments, sensory impairments and severe disability make assessment and management of pain more difficult in both the older and younger residential populations. As well, the consequences of under-recognized and under-treated pain can contribute to depression, anxiety, decreased socialization, as well as mobility issues, sleep impairment, reduced appetite, delayed healing, aggression, agitation and decreased compliance with medical regimes (AGS, 2002; Chodosh et al., 2004; Bird, 2005; Kamel et al., 2001; Hutt et al., 2007; Stolee et al., 2005).

All residents who experience pain require a comprehensive approach that addresses the barriers to effective pain management and an organization wide, interdisciplinary effort to make pain assessment and management a priority for resident care. Good pain management can improve the resident’s function and increase independence, which in turn can decrease health care costs (Larsen, 2004). In addition, a “key benefit of appropriate pain management is increased satisfaction for [residents] and their families as well as health care providers” (CPS, 2005, p. 5; Brennan et al., 2007; Vega-Stromberg et al., 2002).

Due to the high prevalence of pain in residents, screening, comprehensive assessment and interdisciplinary care planning is required. Interdisciplinary team members who can contribute to successful management of pain include:

- Residents and their family members
- Nursing – RN, RPN, LPN; advanced practice nurses, e.g. Clinical Nurse Specialists, Nurse Practitioners
- Residential Care Aides

- Medicine – GP, pain or palliative care experts
- Rehabilitation – OT, PT, Recreation Therapy, Activity workers
- Pharmacy
- Social Work
- Chaplain
- Dietitian, dietary staff
- Support staff – housekeeping, maintenance

In order to provide excellent care, members of the interdisciplinary team need expertise in the assessment and management of pain.

Guiding Principles to the Assessment and Management of Pain

- Residents have the right to the best pain relief possible (FHA, 2006; RNAO, 2007)
- Pain is subjective and a highly variable experience for each person (FHA, 2006; RNAO, 2007)
- Pain is multidimensional involving physical, social, emotional and spiritual components (FHA, 2006; RNAO, 2007)
- Pain is what the resident says it is (McCaffery & Pasero, 1999)
- Any persistent pain that has an impact on physical function, psychological function, or quality of life should be considered a significant problem (AGS, 2002)
- Absent physiological and behavioural indicators or unreliable self-report do not necessarily mean an absence of pain (CPS, 2005)
- Resident and family goals should drive pain management decisions (FHA, 2006; RNAO, 2007; CPS, 2005; VCH, 2007)
- Effective pain assessment and management is complex and requires coordinated interdisciplinary interventions and evaluation (FHA, 2006; RNAO, 2007)
- Health care professionals are legally and ethically obligated to advocate for change in the treatment plan where pain relief is inadequate (FHA, 2006; RNAO, 2007)

Pain and the Resident Assessment Instrument – Minimum Data Set 2.0 (InterRAI MDS 2.0)

All residential care facilities have been mandated by the British Columbia Ministry of Health to complete a functional assessment, the InterRAI-MDS 2.0, on all newly admitted residents after March 31, 2009. Section J screens for the frequency (none, less than daily, and daily) and intensity (mild, moderate, or horrible or excruciating) of pain. Teno (2004) reports that staff tend to underestimate the frequency and severity of pain on the Minimum Data Set (MDS), a common problem with all staff interpretations of pain in residents. Fisher et al. (2002) note that a more comprehensive assessment, including care aides' observations, is needed to augment the MDS data elements. Currently there is no InterRAI Residential Assessment Protocol that is triggered when pain is identified. However, an InterRAI Client Assessment Protocol for Pain is being developed and, when it is available, will be a useful guide for the further assessment and treatment of pain by clinical staff.

Ethics and Advocacy

Any member of the interdisciplinary team can initiate a discussion regarding any identified need for change in the resident's treatment plan. The health care provider supports his/her recommendations with appropriate evidence, providing a clear rationale for the need for change. (RNAO, 2007; CPS, 2005; AGS, 2002; Herr et al., 2006). Reporting unrelieved pain is an ethical responsibility (RNAO, 2007; O'Malley, 2005). In complex pain situations, the interdisciplinary team should advocate for consultation with a pain management expert (RNAO, 2007; CPS, 2005; AGS, 2002).

Quality Improvement

It is advisable to use quality improvement principles, tools and resources and/or seek consultation from a quality improvement expert when planning initiatives requiring change in clinical practice such as the implementation process of assessing and managing pain.

Canadian Council on Health Service Accreditation (CCHSA) Long Term Care Standards (2007)

Those facilities/organizations committed to meeting CCHSA long term care standards should note Standard 7.4 requires a process for assessing and managing the resident's pain.

Facility Self-Assessment of Pain Management Practices

Facility self-assessment is an essential first step in evaluating the current clinical practice in pain assessment and management, identifying key areas where improvements and education are needed and subsequently measuring the success of improvements made. Appendix 1 has an example of a self-assessment tool from the Canadian Pain Society, adapted here for residential care.

Standards

The standards that follow are adapted from the Canadian Pain Society (CPS) and Canadian Council of Health Services Accreditation (CCHSA) to reflect the residential population. Recent literature was also reviewed for current best practices.

Standard 1

1.0 Each resident will be assessed for pain (a) on moving in, (b) on change of condition, (c) when there is a change in the care plan, (d) when there is a change in treatment (pharmacological and non-pharmacological) and (e) routinely thereafter

Self-report of pain is a valuable tool in assessing for the presence of pain. However the older adult may be reluctant to report pain, desire to remain stoic, view pain as a consequence of aging, have low expectations of pain relief, fear the side effects of medications, or view pain as a disease (Schofield, 2006; Hutt et al., 2007).

1.1 Screening

- 1.1.1 All residents should be **screened for the presence of pain within 24 hours of admission** and at least once a day thereafter (RNAO, 2007)
- 1.1.2 All residents who are able to self-report can be asked about the presence of pain, ache, heaviness, discomfort (RNAO, 2007)
- 1.1.3 For those residents who are non-verbal (e.g. severe dementia), behavioural indicators can be useful in identifying the presence of pain (RNAO, 2007; CPS, 2005, Herr et al., 2006)

1.2 The team completes a comprehensive pain assessment using a standardized clinical measure

Upon identification of the high risk or presence of pain, a thorough assessment includes the following: (RNAO, 2007; VCH, 2007; AGS, 2002; CPS, 2005)

- 1.2.1 Physical examination, appropriate laboratory and other diagnostic tests to identify the cause of the pain if possible
- 1.2.2 Diagnoses known to have associated pain
- 1.2.3 History of pain (e.g. when did it begin, how long does it last, how often does it occur)
- 1.2.4 Previous pain management strategies (e.g. pharmacological and non-pharmacological; successful or unsuccessful)
- 1.2.5 Values and beliefs – preferences and expectations of resident and family regarding pain and pain management (e.g. resident's/family's goal for pain control)
- 1.2.6 Situational factors – culture, language, ethnic factors
- 1.2.7 Type of pain (e.g. cancer, non-cancer, acute, persistent, neuropathic, nociceptive, mixed)

- 1.2.8 Location of pain
- 1.2.9 Quality of pain (e.g. aching, throbbing, dull, tingling, shooting, stabbing, burning, cramping, crushing)
- 1.2.10 Provoking or precipitating factors (e.g. movement, touch)
- 1.2.11 Factors that relieve the pain (e.g. staying still, moving, taking medication) and extent of pain relief achieved
- 1.2.12 Pain related symptoms (e.g. nausea, weakness, changes in colour or temperature of the painful area)
- 1.2.13 Timing (occasional, intermittent, constant; does the pain differ with the time of day)
- 1.2.14 Radiation of pain
- 1.2.15 Impact of pain on function and activities of daily living (e.g. mobility, sleep, appetite, social activities; ask resident: How is pain affecting you and your family?)
- 1.2.16 Intensity of pain (e.g. at its worst in the past 24 hours, at rest and on movement)
- 1.2.17 Medication usage and adverse effects from current and previous analgesics (e.g. nausea, sedation, constipation)

Fraser Health Authority has a Pain Assessment Acronym OPQRTSUV that staff may find a useful reminder in pain assessment (FHA, 2006) (see Appendix 2).

1.3 Scales for residents able to self-report

- 1.3.1 Pain intensity scales should be used to determine the intensity of the pain and evaluate the effectiveness of pain management over time (Herr, Spratt et al., 2004)
- 1.3.2 The same scale should be used consistently for the individual resident on initial and follow-up assessments (AGS, 2002; Hadjistavropoulos et al., 2007)
- 1.3.3 Examples of pain intensity scales that can be used in residential care with residents able to self-report include (Herr et al., 2006; Hadjistavropoulos et al., 2007):
 - ▶ Numeric rating scale (0-5; 0-10). A scale of 0-5 can be less overwhelming to an older adult (Hadjistavropoulos et al., 2007)
 - ▶ Verbal descriptor scale
 - ▶ Faces scale
 - ▶ Pain Thermometer scale

1.4 Pain assessment for residents unable to self-report

Assessing pain in residents who are unable to self-report is complex and difficult. Pateux et al. (2006) found that 49% of cognitively impaired individuals with an MMSE of less than 11 (out of 30) were able to self-report their pain, and that only 40% of those individuals were on regularly prescribed analgesics. They also demonstrated that nursing staff observational scales for non-verbal cues underreported the person's pain. "Although cognitively impaired older persons may

be able to answer yes and no questions about whether they have pain, they may have difficulty identifying the location of their pain or describing temporal variations in their pain...Complex pain assessment measures that require abstract thinking or discrimination may be too difficult for the cognitively impaired persons to use reliably” (Stolee et al., 2005, p. 319). Further, pain itself can exacerbate cognitive impairment (Larsen, 2004).

A resident’s inability to verbally communicate their pain experience is a significant barrier to pain assessment. “Assessing pain in non-verbal adults can be a challenge as the most reliable indicator of pain, the patient’s own statement, cannot be used.... Since these patients are most vulnerable, the interprofessional team may use a variety of standardized measures including observation of behaviour” (CPS, 2005, p. 14; Warden et al., 2005), and verbal short sentences in words the resident uses to assess for the presence of pain (Pateux et al., 2006).

“Behavioral observations involve assessment of specific, discrete non-verbal behaviours. Estimating levels of pain from these observations of behaviors is the most common approach to pain assessment in ... those with cognitive impairments.... [T]he range of possible responses is large and no particular set has been shown to be consistent with particular pain experiences. Another issue with behavioral observations is that many behavioral responses (e.g. crying) are not unique to pain. Therefore, distinguishing between pain and distress or other phenomena such as fear, anxiety or loneliness can be very difficult” (CPS, 2005, p.13; Larsen, 2005; van Iersel et al., 2006; Stolee et al., 2005; Auret et al., 2005; Hadjistavropoulos et al., 2007). Further, for those individuals experiencing persistent pain, typical pain behaviours are often absent (Herr et al., 2006).

For non-verbal residents, signs of pain may include: (AGS, 2002; Cadogan, 2003; For adults who are unable to give a self-report, assessments of behaviour and family or caregiver’s observations are essential. In residential care, the health care providers who know the resident well (e.g. nurses and care aides) have been shown to be effective in recognizing the presence of pain (Fisher et al., 2002; Mentis et al., 2004). However, there are no tools that have strong reliability and validity that can be recommended for broad adoption in clinical practice for persons with advanced dementia (Stolee et al., 2005; Larsen, 2004; McLennon, 2005; van Herk et al., 2007; Smith, 2005; Hutt et al., 2007; Hadjistavropoulos et al., 2007). A tool that is easy for staff to use can increase the likelihood of a systematic interdisciplinary approach to pain assessment and management.

The tool that best works for the situation and the individual resident should be used consistently (Hadjistavropoulos et al., 2007).

1.4.1 Herr et al., 2006; McLennon, 2005)

- ▶ facial expressions (e.g. grimacing, anxious, distressed, frowning, rapid eye blinking)
- ▶ vocal behaviours (e.g. sighing, moaning, calling out, repetitive vocalization)
- ▶ body position (e.g. lying still, distorted posture)
- ▶ changes in activity patterns (e.g. staying in bed, decreased socialization or interest in taking part in activities, wandering)

- ▶ decreased appetite
- ▶ rubbing a body part
- ▶ mental status (e.g. irritability, confusion, restlessness, agitation, aggression)
- ▶ gait changes (e.g. limping, shifting body weight, holding onto supports)
- ▶ resistance to care

1.4.2 The following are tools that have been tested in residential care settings and can be used for residents with severe dementia (Herr et al., 2006):

- ▶ **ADD** - The Assessment Of Discomfort In Dementia Protocol (Kovach et al., 2002)
- ▶ **CNPI** - Checklist Of Nonverbal Pain Indicators (Feldt, 2000)
- ▶ **Doloplus-2** (Lefebvre-Chapiro, 2001; Paurex et al., 2007)
- ▶ **NOPPAIN**: Nursing Assistant administered instrument to assess pain in demented individuals (Snow et al., 2003)
- ▶ **PACSLAC**: The Pain Assessment Checklist for Seniors with Limited Ability to Communicate (Fuchs-Lacelle & Hadjistavropoulos, 2004; Hadjistavropoulos et al., 2007)
- ▶ **PAINAD**: The Pain Assessment In Advanced Dementia scale (Warden et al., 2003; Leong et al., 2007)

2.0 The resident's pain is managed appropriately and routinely monitored for the effectiveness of pain management strategies

2.1 Pharmacological strategies

- 2.1.1 All residents with functional impairment or diminished quality of life as a result of persistent pain are candidates for pharmacological approaches to pain management (AGS, 2002)
- 2.1.2 Staff need access to the most current, evidence based information on effective pharmacological management of pain in the older adult (CPS, 2005; RNAO, 2007; AGS, 2002)
- 2.1.3 Medications are important in managing pain. The basic principles for pharmacological management of pain include:
 - ▶ Use the World Health Organization (WHO) analgesic 3-step ladder guidelines for pain management (<http://www.who.int/cancer/palliative/painladder/en/>)
 - ▶ Give the medication by mouth if possible (RNAO, 2007; CPS, 2005)
 - ▶ Ensure medication coverage around the clock for persistent pain (RNAO, 2007; Hutt et al., 2007; Auret et al., 2005)
 - ▶ Match the medication to the type and intensity of pain, and potential for toxicity (renal or liver impairment) (RNAO, 2007; Hutt et al., 2007; Auret et al., 2005)

- ▶ For persistent pain give analgesics on a regular schedule, not on an as-needed or prn schedule (Won et al., 2004)
- ▶ The elderly usually receive greater peak and longer duration of action from analgesics than younger individuals, therefore initiate medications at a lower dose and increase them slowly (RNAO 2007; CPS 2005; AGS 2002)
- ▶ Titrate the medication upward according to the resident's verbal, behavioural and functional responses, e.g. considering frequency and amount of breakthrough pain medications (RNAO, 2007; CPS, 2005; AGS, 2002; Hutt et al., 2007)
- ▶ Increase the amount of breakthrough medication when the regular analgesic dosage is increased
- ▶ Adjunct or co-analgesics can be useful in reducing the dose of analgesics and their side effects, e.g. corticosteroids, antidepressants, anticonvulsants (RNAO, 2007; CPS, 2005)
- ▶ Meperidine and codeine are NOT recommended for analgesia in residential care (RNAO, 2007; CPS, 2005)
- ▶ There are potential harmful effects of all medications. "Opioids are effective, associated with a low potential for addiction and overall may have fewer long-term risks than other analgesic drug regimens in older person with persistent pain" (AGS, 2002, p. 6-7).
- ▶ Examples of opioids that are useful in the older adult include: hydromorphone, oxycodone, fentanyl, methadone (RNAO, 2007; CPS, 2005)
- ▶ Nausea, constipation and sedation are predictable adverse effects of opioids. Yet these effects can usually be avoided when a prevention treatment strategy is used. Should adverse effects become intolerable for the resident, it is justified to make a change in the opioid or add an adjuvant medication that can enable an opioid dose reduction (CPS, 2005)
- ▶ Equianalgesic charts should be used a guide when changing from one opioid to another or one route to another (CPS, 2005)
- ▶ In non-verbal residents with behaviours that may indicate pain, a trial of analgesics may prove useful in differentiating the cause of the behaviour from non-pain sources (Hadjistavropoulos et al., 2007). Low dose opioids have been effective in validating agitation as a pain behaviour (Kovach et al., 2006) and administration of acetaminophen has increased social interactions (Chibnall et al., 2005)

2.2 Non-Pharmacological strategies

2.2.1 Non-pharmacological strategies are useful in augmenting the effectiveness of medications and usually have minimal side effects. Non-pharmacological methods of treatment should not substitute for adequate pharmacological management, especially with severe pain, but are a useful adjunct (RNAO, 2007).

2.2.2 Selection of non-pharmacological strategies should be based on the resident's preferences, abilities (e.g. cognition) and the interdisciplinary scope of practice and may include (RNAO, 2007; CPS, 2005; AGS, 2002; Hutt et al., 2007):

- ▶ Superficial heat and/or cold (alternating)
- ▶ Massage
- ▶ Relaxation/Stress reduction
- ▶ Imagery
- ▶ Pressure/vibration
- ▶ Music and other therapies, pets, spirituality
- ▶ TENS, ultrasound
- ▶ Acupuncture
- ▶ Physical activity/Rehabilitation therapy to improve joint range of motion, muscle strength, endurance and balance
- ▶ Mobility aids, splints, seating systems for wheelchairs to minimize pain
- ▶ Positioning in bed and chair
- ▶ Interdisciplinary psychosocial support and touch/empathy

2.3 Evaluation/Re-assessment

Monitoring the effectiveness of pain management in residential care includes pain rating, functional status, resident and family preferences, and side effects of medications (CPS, 2005, AGS, 2002; Herr, Titler et al., 2004).

2.3.1 Pain is reassessed on a regular basis according to the type and intensity of pain and the treatment plan (RNAO, 2007)

2.3.2 The following parameters should be monitored on an ongoing basis in persistent pain situations (RNAO, 2007):

- ▶ Current pain intensity, quality and location
- ▶ Intensity of pain at its worst in past 24 hours, at rest and on movement
- ▶ Extent of pain relief achieved – response (reduction on pain intensity scale)
- ▶ Barriers to implementing the treatment plan
- ▶ Effects of pain on activities of daily living, sleep and mood
- ▶ Adverse effects of medications for pain treatment (e.g., nausea, constipation)
- ▶ Level of sedation if an expected side effect
- ▶ Strategies used to relieve pain, both pharmacological and non-pharmacological and their effectiveness

2.3.3 Pain intensity, function and impact on activities is reassessed at each new report of pain and new procedure, when intensity increases, and when pain is not relieved by previously effective strategies (RNAO, 2007)

2.3.4 Effectiveness of intervention (both pharmacological and non-pharmacological) is reassessed after the intervention has reached peak

effect (e.g. for opioids 1 hour after immediate release analgesic) (RNAO, 2007)

- 2.3.5 The residential care staff advocates on behalf of the person for changes to the treatment plan if pain is not being relieved (RNAO, 2007; CPS, 2005; Herr et al., 2006; AGS, 2003)

2.4 The team identifies and consults with pain management experts

- 2.4.1 Pain can be a complex multidimensional problem and therefore effective management requires a variety of strategies involving all health care professionals (CPS, 2005)
- 2.4.2 An interdisciplinary approach is essential. Health care professionals should utilize each others' expertise in working together to help residents and families with pain management (CPS, 2005)
- 2.4.3 The availability of clinical experts in pain assessment and management is a component of effective pain care (CPS, 2005; RNAO, 2007)

3.0 The team documents and shares the results of pain management strategies

Effective pain management includes ongoing communication. Documentation is a means of communicating pain assessment and interventions utilized for pain, as well as the resident's response to the interventions.

- 3.1 Pain documentation contains all the information/components of a pain assessment and occurs as frequently as the assessment (CPS, 2005)
- 3.2 Documentation of pain assessment and management should be readily visible and available to all health care providers involved in care of the resident (CPS, 2005; Herr et al., 2006)
- 3.3 Documentation of education provided to residents or families (Herr et al. 2006)
- 3.4 If pain is identified as a focus of care, there will be a written, individualized, resident care plan (RNAO, 2007; VCH, 2007; CPS, 2005)
 - 3.4.1 The resident/family identifies the goals in relation to pain management, either as a number on a pain scale or in relation to an activity the resident wishes to do
 - 3.4.2 The interdisciplinary team members collaborate with the resident/family to establish a plan for pain relief, considering the resident and family goals for pain relief
 - 3.4.3 The interventions include both pharmacological and non-pharmacological strategies
 - 3.4.4 The care plan is available to all health care providers involved in the care of the resident
 - 3.4.5 Re-assessment time frames are stated

4.0 Residents, families and staff are educated about evidence-based pain management assessment and management strategies

Educating residents and their families about pain and the management of pain has been shown to decrease anxiety, pain intensity, and misbeliefs regarding pain management. The Canadian Pain Society identifies that the “best pain management involves patients, families and health professionals” (CPS, 2005, p. 20).

Education for staff is also an essential component in the management of pain (CPS, 2005; AGS, 2002; Innis et al., 2004; Linkewich et al., 2007). “Building an organizational commitment to pain management requires a sustainable infrastructure that supports staff development, training, preceptorship, mentorship, and a comprehensive approach in the use of evidence-based strategies for optimal pain management” (CPS, 2005, p 24).

4.1 Education about basic pain management principles, pain assessment, pharmacological and non-pharmacological methods of treatment should be provided to all residents and their families (CPS, 2005; RNAO, 2007)

- 4.1.1 Provide the resident and their family/care providers with information about pain and the measures used to treat and prevent pain in order to treat and prevent adverse effects and to correct myths associated with the treatment of pain
- 4.1.2 Identify the roles and expectations of the resident, family and staff
- 4.1.3 Listen carefully to resident or family stated histories or explanations of their perceptions for clues to assist in clarifying inaccurate statements or beliefs
- 4.1.4 Provide literature written at a grade 4 or 5 level
- 4.1.5 Ensure that residents understand the importance of promptly reporting unrelieved pain, changes in their pain, new sources or types of pain and adverse effects from analgesics
- 4.1.6 Clarify, when appropriate, the differences between addiction, tolerance and physical dependence to counteract misbeliefs that can prevent optimal use of pharmacological methods for pain management
- 4.1.7 Teach residents and families (as proxy recorders) to document pain assessment on the appropriate tools when care is provided, if appropriate. This will facilitate their active involvement in the treatment plan
- 4.1.8 Provide instruction to the resident/care provider on communicating unrelieved pain to the appropriate clinician and supporting them in advocating on their own behalf
- 4.1.9 Provide residents and families/care providers with a written copy of the treatment plan to promote their decision-making and active involvement in the management of pain. Changes to the treatment plan will be documented and communicated to everyone involved in the implementation of the plan

4.2 The Organization Trains and Updates Staff on Evidenced-based Strategies to Prevent, Minimize or Relieve Pain (CPS, 2005; RNAO, 2007; AGS, 2002; Hutt

et al., 2007; McMillan et al., 2005; Neville et al., 2006; McCaffery et al., 2000; McCaffery & Robinson, 2002; Textor & Porock, 2006; Mathews & Malcolm, 2007)

- 4.2.1 Pain assessment and management should be included in orientation programs
- 4.2.2 Professional development opportunities on pain management should be made available to all health care professionals
- 4.2.3 Education programs should be designed to facilitate change in knowledge, skill, attitudes and beliefs about pain assessment and management.
- 4.2.4 Education programs should address personal and residents' cultural, attitudinal and system-related barriers to pain relief
- 4.2.5 There are many beliefs and fears about using opioids, which prevent optimal use of these agents in controlling pain. For this reason, it is important to learn the difference between physical dependence, tolerance and opioid addiction
- 4.2.6 Education on preferred medications and dosing for the elderly
- 4.2.7 Discussion of goals for pain management in the elderly

References

- Alexander, B.J., Plank, P., Carlson, M.B., Hanson, P., Picken, K., & Schwebke, K. (2005). Methods of pain assessment in residents of long-term care facilities: a pilot study. *Journal of American Medical Directors Association*, 6, 137-143.
- American Geriatrics Society (2002). The management of persistent pain in older persons. *Journal of the American Geriatrics Society*, 50(6 Supp), S205-S224.
- Auret, K. and Schug, S.A. (2005). Underutilization of opioids in elderly patients with chronic pain: approaches to correcting the problem. *Drugs and Aging*, 22(8), 641-654.
- Bird, J. (2005). Assessing pain in older people. *Nursing Standard*, 19(19), 45-52.
- Brennan, F., Carr, D.B., & Cousins, M. (2007). Pain management: a fundamental human right. *Anesthesia & Analgesia*, 105(1), 205-221.
- Cadogan, M.P. (2003). Assessing pain in cognitively impaired nursing home residents: the state of the science and the state we're in. *Journal of the American Medical Directors Association*, 4(1), 50-51.
- Canadian Council on Health Service Accreditation. (2007). CCHSA Patient/Client Safety Goals and Required Organization Practices (ROPs).
- Canadian Pain Society (2005). Accreditation pain standard: making it happen! Available online at http://www.canadianpainsociety.ca/accreditation_manual.pdf Accessed October 29, 2007.
- Chibnall, J.T., Tait, R.C., Harman, B., and Leubbert, R.A. (2005). *Journal of the American Geriatrics Society*, 53, 1921-1929.
- Chodosh, J., Solomon, D.H., Roth, C.P., Chang, J.T., MacLean, C.H., Ferrell, B.A., Shekelle, P.G., & Wenger, N.S. (2004). The quality of medical care provided to vulnerable older patients with chronic pain. *Journal of the American Geriatric Society*, 52(5), 756-761.
- Feldt, K.S. (2000). Checklist for nonverbal pain indicators. *Pain Management Nursing*, 1(1), 13-21.
- Fisher, S. E., Burgio, L. D., Thorn, B.E., Allen-Burge, R., Gerstle, J., Roth, D., and Allen, S.J. (2002). Pain assessment and management in cognitively impaired nursing home residents: Association of certified nursing assistant pain report, Minimum Data Set pain report, and analgesic medication use. *Journal of the American Geriatrics Society*, 50, 152-156.
- Fraser Health Authority (2006). Persistent Pain: Clinical Practice Guideline.

- Fox, P., Raina, P., and Jadad, A. (1999). Prevalence and treatment of pain in older adults in nursing homes and other long-term care institutions: a systematic review. *Canadian Medical Association Journal*, 160, 329-333.
- Fuchs-Lacelle, S. & Hadjistavropoulos, T. (2004). Development and preliminary validation of the Pain Assessment Checklist for Seniors With Limited Ability to Communicate (PACSLAC). *Pain Management Nursing*, 5(1), 37-49.
- Hadjistavropoulos, T., Herr, K., Turk, D., Fine, P.G., Dworkin, R.H., Helme, R., Jackson, K., Parmelee, P.A., Rudy, T.E., Beattie, B.L., Chibnall, J.T., Craig, K.D., Ferrell, B.R., Ferrell, B.A., Fillingim, R.B., Gagliese, L., Gallagher, R., Gibson, S.J., Harrison, E.L. Katz, B., Keefe, F.J., Lieber, S.J., Lussier, D., Schmader, K.E., Tait, R.C., Weiner, D.K., and Williams, J. (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. *Clinical Journal of Pain*, 23(1), S1-S43.
- Herr, K., Coyne, P., McCaffery, M., Manworren, R., Merkel, S., Key, T., Pelosi-Kelly, J. and Wild, L. (2006). Pain assessment in the non-verbal patient: position statement with clinical practice recommendations. American Society for Pain Management Nursing. Available on-line at <http://www.aspmn.org/Organization/documents/NonverbalJournalFINAL.pdf> Accessed October 29, 2007.
- Herr, K.A., Spratt, K., Mobily, P.R., & Richardson G. (2004). Pain intensity assessment in older adults: use of experimental pain to compare psychometric properties and usability of selected pain scales with younger adults. *Clinical Journal of Pain*, 20(4), 207-219.
- Herr, K., Titler, M.G., Schilling, M.L., Marsh, J.L., Xianjin, X., Ardery, G., Clarke, W.R., & Everett, L.Q. (2004). Evidence-based assessment of acute pain in older adults: current nursing practices and perceived barriers. *Clinical Journal of Pain*, 20(5), 331-340.
- Horgas, A.L., & Elliott, A.F. (2004). Pain assessment and management in persons with dementia. *Nursing Clinics of North America*, 39, 593-606.
- Innis, J., Bikaunieks, N., Petryshen, P., Zellermeier, V., & Ciccarelli, L. (2004). Patient satisfaction and pain management: an educational approach. *Journal of Nursing Care Quality*, 19(4), 322-327.
- Hutt, E., Buffum, M.D., Fink, R., Jones, K.R., and Pepper, G.A. (2007). Optimizing pain management in long-term care residents. *Geriatrics Aging*, 10(8), 523-527.
- International Association for the Study of Pain. http://www.iasp-pain.org/AM/Template.cfm?Section=General_Resource_Links&Template=/CM/HTMLDisplay.cfm&ContentID=3058#Pain Accessed October 29, 2007.
- Kamel, H.K., Phlavan, M., Malekgoudarzi, B., Gogel, P., & Morley, J.E. (2001). Utilizing pain assessment scales increases the frequency of diagnosing pain among elderly nursing home residents. *Journal of Pain and Symptom Management*, 21(6), 450-455.

- Kovach, C.R., Noonan, P.E., Griffie, J., Muchka, S., and Weissman, D.E. (2002). The assessment of discomfort in dementia protocol. *Pain Management Nursing*, 3(1), 16-27.
- Kovach, C.R., Noonan, P.E., Schlidt, A.M., Reynolds, S., and Wells, T. (2006). The Serial Trial Intervention: an innovative approach to meeting needs of people with dementia. *Journal of Gerontological Nursing*, 32(4), 18-27.
- Larson, M.J. (2004). Assessing pain in cognitively impaired older adults. *Nursing Standard*, 18(38), 33-39.
- Lefebvre-Chapiro, S. (2001). The Doloplus-2 scale: evaluating pain in the elderly. *European Journal of Palliative Care*, 8(5), 191-194.
- Leong, I., Chong, M.S., and Gibson, S. (2006). The use of a self-reported pain measure, a nurse-reported pain measure and the PAINAD in nursing home residents with moderate and severe dementia: a validation study. *Age & Ageing*, 35(3), 252-256.
- Linkewich, B., Sevean, P., Habjan, S., Poling, M., Bailey, S., & Kortess-Miller, K. (2007). Enhancing nurses' pain management knowledge. *Canadian Nurse*, 103(4), 24-28.
- Matthews, E., & Malcolm, C. (2007). Nurses' knowledge and attitudes in pain management practice. *British Journal of Nursing*, 16(3), 174-179.
- McCaffery, M., Ferrell, B.R., & Pasero, C. (2000). Nurses' personal opinions about patients' pain and their effect on recorded assessments and titration of opioid doses. *Pain Management Nursing*, 1(3), 79-87.
- McCaffery, M. and Pasero, C. (1999). *Pain: Clinical Manual* (2nd ed.). St. Louis: Mosby.
- McCaffery, M., & Robinson, E.S. (2002). Your patient is in pain: here's how you respond. *Nursing2002*, 32(10), 36-45.
- McLennon, S.M. (2005). *Persistent pain management*. Iowa City: University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core.
- McMillan, S.C., Tittle, M., Hagan, S.J., & Small, B.J. (2005). Training pain resource nurses: changes in their knowledge and attitudes. *Oncology Nursing Forum*, 32(4), 835-842.
- Mentes, J.C., Teer, J., and Cadogan, M.P. (2004). The pain experiences of cognitively impaired nursing home residents: perceptions of family members and certified nursing assistants. *Pain Management Nursing*, 5(3), 118-125.
- Neville, C., McCarthy, A., & Laurent, K. (2006). Pain management skills of regional nurses caring for older people with Dementia: a needs analysis. *Collegian*, 13(2), 31-36.

- O'Malley, P. (2005). The undertreatment of pain: ethical and legal implications for the Clinical Nurse Specialist. *Clinical Nurse Specialist, 19*(5), 236-237.
- Paurex, S., Herrmann, F. R., Michon, A., Giannakopoulos, P., and Gold, G. (2007). Psychometric properties of the Doloplus-2 observational scale and comparison to self-assessment in hospitalized elderly. *Clinical Journal of Pain, 23*(9), 774-779.
- Pateux, S., Michon, A., Guedira, M., Emond, H., LeLous, P., Samaras, D., Michel, J-P., Herrmann, F., Giannakopoulos, P, and Gold, G. (2006). Pain in severe dementia: self-assessment or observational scales? *Journal of the American Geriatrics Society, 54*, 1040-1045.
- Registered Nurses Association of Ontario (2007). Nursing best practice guideline: assessment and management of pain (Supplement). Toronto: RNAO.
- Schofield, P. (2006). Pain management in care homes. *Journal of Community Nursing, 20*(6), 30-34.
- Smith, M. (2005). Pain assessment in nonverbal older adults with advanced dementia. *Perspectives in psychiatric care, 41*(3), 99-113.
- Snow, A.L., Weber, J.B., O'Malley, K.J., Beck, C., Bruera, E., Ashton, C., and Kunik, M.E. (2004). NOPPAIN: a nursing assistant-administered pain assessment instrument for use in dementia. *Dementia and Geriatric Cognitive Disorders, 17*(3), 240-6.
- Stolee, P., Hillier, L.M., Esbaugh, J., Bol, N., McKellar, L., and Gauthier, N. (2005). Instruments for the assessment of pain in older persons with cognitive impairment. *Journal of the American Geriatrics Society, 53*, 319-326.
- Teno, J., Kabumoto, G., Wetle, T., Roy, J., and Mor, V. (2004). Daily pain that was excruciating at some time in the previous week: prevalence, characteristics, and outcomes in nursing home residents. *Journal of the American Geriatrics Society, 52*, 762-767.
- Textor, L.H., & Porock, D. (2006). The pain management knowledge of nurses practicing in a rural Midwest retirement community. *Journal for Nurses in Staff Development, 22*(6), 307-312.
- van Herk, R., van Dijk, M., Baar, F.P.M., Tibboel, D., and de Wit, R. (2007). Observation scales for pain assessment in older adults with cognitive impairments or communication difficulties. *Nursing Research, 56*(1), 34-43.
- van Iersel, T., Timmerman, D., and Mullie, A. (2006). Introduction of a pain scale for palliative care patients with cognitive impairment. *International Journal of Palliative Nursing, 12*(2), 54-59.

- Vancouver Coastal Health (2007). Community Palliative Care: Clinical Practice Guidelines. Vancouver: Vancouver Coastal Health.
- Vega-Stromberg, T., Holmes, S.B., Gorski, L., and Johnson, B.P. (2002). Road to excellence in pain management: research, outcomes and direction (ROAD). *Journal of Nursing Care Quality*, 17(1), 15-29.
- Warden, V., Hurley, A.C., and Volicer, L. (2003). Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. *Journal of the American Medical Directors Association*, 4(1), 9-15.
- Won, A.B., Lapane, K.L., Vallow, S., Schein, J., Morris, J.N. and Lipsitz, L.A. (2004). Persistent non-malignant pain and analgesic prescribing patterns in elderly nursing home residents. *Journal of the American Geriatrics Society*, 52, 867-874.
- World Health Organization. WHO Pain Relief Ladder.
<http://www.who.int/cancer/palliative/painladder/en/> Accessed November 29, 2007.

Appendix 1

Evaluation and Changing Current Practice

What is the Current Pain Management Practice in your Organization?

Current practice must be assessed in order to know how your organization is practicing and where improvements/education is needed. The following Institutional Assessment may be helpful when doing an initial assessment of your organization’s pain management practices.

Institutional Assessment:

Adapted from Canadian Pain Society (200??) to a residential population

Assessment and Documentation	Yes	No	Don't know
Is there a written standard of practice that articulates the method and frequency for assessment and documentation of pain?			
Do documentation forms screen for pain on admission?			
Do documentation forms provide for the ongoing recording of assessment, intervention and trends of pain relief?			
Does your method of pain documentation place pain in a highly visible and prominent position that encourages regular review by the interprofessional team?			
Does your system assure the communication of the pain management plan as resident’s transition across settings?			
Do health care professionals have access to the pain assessment tools needed to assess pain across populations (e.g.: younger and older adults, cognitively impaired, inability to communicate verbally)?			
Appropriate Management of Pain			
Are the necessary analgesics available on formulary?			
Do you do drug utilization reviews to monitor prescribing practices?			
Is the appropriate analgesic at the appropriate interval and appropriate dosage being used?			
Are there appropriate opioid alternatives for residents who do not respond to codeine?			
Is the interprofessional team aware of the maximum daily dose and concerns regarding neurostimulatory side effects of meperidine?			
Are specialized techniques for analgesic administration available (e.g.: IV PCA, Epidural analgesia, Continuous peripheral nerve blocks)?			
Are there tools to help the interprofessional team select and dose analgesics (e.g.: algorithms, protocols, formulary guidelines or preprinted orders)?			
Is there a mechanism in place to manage procedural pain?			
Are there guidelines in place for monitoring residents who have received analgesics? Including the assessment and management of side effects?			
Are there non-pharmacological resources available in your organization?			
Can the interprofessional team readily provide or access non-pharmacological interventions for pain management?			
Are there mechanisms in place to elicit feedback regarding the effectiveness of the pain management from residents and family members (e.g.: resident and/or family satisfaction survey, internal measures, and external measures)?			

Pain Consultation	Yes	No	Don't know
Are there standards/guidelines that define the maximum acceptable pain intensity and triggers for change in plan of care or consultation?			
Are there expert preceptors/role models in pain management that are readily available to health care providers?			
Is there a clear line of consultation for difficult pain problems?			
Do you have a pain team or pain specialist that you can refer to or discuss difficult cases with?			
Resident and Family Education			
Are all residents informed verbally and in an electronic or printed format that effective pain relief is an important part of their care, that it is essential that they report unrelieved pain/discomfort, and that health care providers respond quickly to resident's requests for pain management?			
Is information about pain management integrated in resident education classes or educational materials?			
Health Care Professional's education			
Has the organization completed a needs assessment regarding health care professional's knowledge and attitudes about pain management?			
Is information about pain management incorporated in health care provider's orientation programs?			
Are there educational resources on pain management for health care providers to access (in-services, self-directed learning packages, videos, printed materials)?			
Are there ongoing opportunities for case presentations or teaching rounds on residents with pain problems?			

The Canadian Pain Society example of an institutional assessment of current pain management practices is also available on-line at:

http://www.canadianpainsociety.ca/accreditation_manual.pdf

Appendix 2

Fraser Health Authority Pain Assessment Acronym

FH Persistent Pain Clinical Practice Guideline, Section 5

History

- All documentation will be reviewed for a history of persistent pain or suffering related to chronic conditions and coexisting health problem.

Interview

- The resident and their supports will be asked the following questions to determine the pain pattern and effective pain management strategies. Do use synonymous terms such as: discomfort, sore, aching, hurt.

0 - Onset:

- How long have you been experiencing this persistent pain?
- What time of day does the pain start?

P - Pattern/Place:

- Location(s) of pain.
- Pattern - When is it worse e.g., on wakening, during activity. When does it ebb? Do activities, positions increase/decrease pain? How long does it last?

Q - Quality:

- What is it like to have pain?
- Describe your pain: aching, throbbing, burning.
- How is it affecting you?
- Does it affect others around you? How?

R - Relieving/Aggravating factors:

- What do you believe causes the pain?
- What makes your discomfort better? Worse?

S - Sleep/Severity:

- Intensity of symptoms (0-5)
- How bothered are you by this pain? (0-5)

T - Treatment:

- What have you tried? What works? What doesn't work? E.g. over the counter medications, heat, other therapies?
- Have you had previous investigations? What are the results if known?
- How many doctors have you seen to manage the pain? Have you seen any pain specialist? Are you still seeing them? If not, why did you stop?

- What previous medications have been used for pain relief? Were they useful? Did you suffer from any side-effect? What were the side-effects? Why did you stop using these medications?
- Do you or your family have any concern about the medications and/or treatment? e.g. opioids use?
- What previous therapies have been used for pain relief - PT, naturopath? Were they useful? Why did you stop using the treatments?
- Have you had a recent injury? Please describe.

U - Understanding:

- What do you understand about your discomfort?
- What does having this discomfort mean to you?
- Do you or your family have any concern that pain is interfering with your preferred lifestyle? e.g. sleep, nutrition, daily routines.

V - Values/Concerns:

- What is an acceptable pain level for you?
- What are your hopes/goals? e.g. to have a good sleep, to be able to walk each day, etc.