Pain Management

A person-centered holistic approach

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Pain Assessment & Management in Long Term Care

Outline:

- Why is this topic important?
  - Prevalence
- Principles of person-centered Approach
- Principles and Components of a Good Pain Management Program
- Strategies
  - Assessment Tools
  - Pharmacological and Non-Pharmacological Mgt.
Pain:

“Whatever the experiencing person says it is, existing whenever the resident says it does. An unpleasant sensory & emotional experience associated with actual or potential tissue damage, or described in terms of such damage, or both.”

There are types

Involves four neurophysiological processes
Studies

1990’s

- 49% of hospitalized patients in study reported a pain level between 4-10 after analgesic administration.
- Hispanic patients were half as likely to receive pain medication as non-Hispanic white patients.

1998

- 67% of patients interviewed in a cancer pain study reported pain sufficient enough to require daily analgesics and only 42% of these felt pain management was sufficient.
Importance and Prevalence

- Number one reason why people seek medical attention is acute pain
- Chronic pain: 50 million of the 75 million who suffer from pain – suffer from chronic pain
  - Back and neck; arthritis; headaches; neuropathic
- Community-dwelling elderly – 25-50%
- Nursing home-dwelling elderly – 45-80%
Importance and Prevalence

- Providers of care, physicians and government agencies need to work together
- It is a publicly reported measure
- It is undertreated for a number of reasons
- Has a negative impact
Consequences

- Prolonged hospital stays
- Physiological
- Delayed recovery
- Increased healthcare costs
- Depression & increased suicide risks
- Altered self-image & needless suffering
- Economic & social impacts greater than for any single disease entity
- Loss of productivity
Physiological Consequences

- Endocrine
- Cardiovascular
- Respiratory
- Gastrointestinal
- Musculoskeletal
- Immune
- Genitourinary
Core Principles

- Resident right to assessment and management
- Pain is subjective – self-report most reliable
- Physiological and behavioral symptoms do not replace
- Assessment tools must be appropriate for the population being treated
- Pain can exist without a physical cause
- Uniform pain threshold & tolerance does not exist
- Residents with chronic pain may be more sensitive to pain caused by acute episodes and often tolerate pain at a higher level
- Unrelieved pain has physical & psychological consequences – assessment should address both
GOALS

- Recognition (requires nurses to be aware of their own beliefs)
- Appropriate assessments & care plans
- Appropriate consults
- Appropriate treatments
- Improved functioning – highest practicable well-being
- Improved quality of life
Checklist

- Consider pain as the first vital sign that is best measured by the patient.
- Ask about the presence of pain when examining an older person.
- Console patient for atypical manifestations of pain in the elderly, such as changes in function or gait, withdrawn or agitated behavior, or increased confusion.
- Use standard geriatric assessment tools to evaluate function, affect, cognition, gait, and psychosocial issues.
- Rely on the input of caregivers, particularly in elderly patients with cognitive impairment and communication disorders.
- Do a comprehensive pain assessment evaluating pain quality, intensity, and factors that exacerbate or relieve the pain.
- Use standard pain scales such as a numerical scale, a pain thermometer scale, or a visual analog scale.
- Identify the etiology of pain in the elderly (keeping in mind that it may be multifactorial) by use of geriatric assessment tools, the history and physical examination, and appropriate diagnostic tests.
- Conduct a careful structural examination to identify regions of somatic dysfunction.
- Monitor and measure presence of pain regularly by use of a pain log or diary and by readministering the pain scales to assess the efficacy of the intervention.
THE FIRST STEP IN TREATING PAIN IS TO RECOGNIZE IT THAT YOUR RESIDENT HAS IT!
PAIN ASSESSMENT TOOLS
Pain assessment tools

- Unidimensional scales
  - Numeric
  - Visual
  - Categorical

- Multidimensional tools
  - Brief pain inventory
  - Initial – Form or Narrative
  - Quarterly – Form or Narrative
  - Other
UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

WONG-BAKER FACIAL GRIMACE SCALE

<table>
<thead>
<tr>
<th>Scale Value</th>
<th>Pain Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No pain</td>
</tr>
<tr>
<td>1-2</td>
<td>MILD</td>
</tr>
<tr>
<td>3-4</td>
<td>MILD</td>
</tr>
<tr>
<td>5-6</td>
<td>MODERATE</td>
</tr>
<tr>
<td>7-8</td>
<td>MODERATE</td>
</tr>
<tr>
<td>9-10</td>
<td>SEVERE</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIVITY TOLERANCE SCALE</th>
<th>NO PAIN</th>
<th>CAN BE IGNORED</th>
<th>INTERFERES WITH TASKS</th>
<th>INTERFERES WITH CONCENTRATION</th>
<th>INTERFERES WITH BASIC NEEDS</th>
<th>BEDREST REQUIRED</th>
</tr>
</thead>
</table>

- 0: No pain
- 1-2: Can be ignored
- 3-4: Interferes with tasks
- 5-6: Interferes with concentration
- 7-8: Interferes with basic needs
- 9-10: Bedrest required

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Simple Descriptive Pain Distress Scale

None   Annoying   Uncomfortable   Dreadful   Horrible   Agonizing

0–10 Numeric Distress Scale

No pain   Distressing pain   Unbearable pain

0   1   2   3   4   5   6   7   8   9   10

Visual Analog Scale (VAS)

No distress   Unbearable distress
Treatment

- Medications
  - PRN vs Routine

- Non-pharmacological treatment
Checklist

- Consider age-related alterations of drug metabolism resulting in increased drug sensitivity and adverse reactions while using pharmacologic interventions for pain management in the elderly.
- When considering pharmacologic interventions, keep in mind that pain is often unrecognized in the elderly and the elderly are often undertreated for pain.
- Start with the lowest possible dose, and proceed slowly to increase dose.
- Consider acetaminophen as the drug of choice for mild to moderate musculoskeletal pain.
- Nonsteroidal anti-inflammatory drug use should be avoided as much as possible for the treatment of elderly patients who have persistent pain.
- Consider opioid analgesics for moderate to severe nociceptive pain in the elderly.
- Use sustained-release opioids for continuous pain and short-acting preparations for breakthrough or episodic pain.
- Titrate opioid dose based on use of medications for breakthrough pain.
- Prevent constipation with opioid use by recommending a prophylactic bowel regimen.
- Anticipate and manage opioid side effects such as sedation, confusion, and nausea until tolerance develops.
- Avoid the use of opioids that have frequent adverse reactions in the elderly, such as propoxyphene, meperidine hydrochloride, and methadone hydrochloride.
- Closely monitor patients on long-term analgesic therapy for side effects and drug-drug and drug-disease interactions.
- Consider adjuvant analgesics such as the anticonvulsant gabapentin for the management of neuropathic pain.
Pharmacological

- Many med options
- Non-opiod
  - Anti-inflammatory
  - Anti-anxiety agents
  - Muscle relaxants
  - Pain perception modifiers
- Opiods
- Anti-epileptics
- Antidepressants
- Nerve blocks – local anesthetics
- Intraspinal delivery systems
Pharmacological principles

- Optimize administration
- PRN vs routine
- Start with a low dose and slowly titrate to the lowest effective dose
- Patches are slow to work initially and another prn medication may be needed for breakthrough pain. Patches may require body fat to be effective
Pharmacological principles

- For chronic pain, use an analgesic around the clock
- For breakthrough pain, use fast onset, short-acting analgesics
- Establish a goal for pain management
- Monitor for & manage side effects. Try to avoid oversedation
- Differentiate among tolerance, physical dependence, & addiction & appropriately modify therapy
Pharmacological principles

- Reassess effectiveness routinely
- Adjuvant drugs may be needed such as Amitryptyline
- Ibuprofen is not the medication of choice if the resident has GERD
Pharmacological principles

- Start with a non-opioid analgesic for mild pain (Adjuvant therapy is optional)
- For mild to moderate pain not relieved by a non-opioid analgesic attempt a weak opioid plus a non-opioid analgesic (Adjuvant therapy is optional)
- Avoid use of placebos
Pharmacological principles

- For moderate to severe pain or pain not relieved by weak opioid, consider a strong opioid with or without a non-opioid analgesic (Adjuvant therapy is optional)
Checklist

- Realize the importance of nonpharmacologic approaches to pain management, both alone or in combination with analgesics, as a means of avoiding the high incidence of adverse drug reactions in the elderly.
- Recognize the importance and efficacy of patient and caregiver education in the management of pain, enabling the patient and caregiver to understand the goals of therapy, method of pain assessment, appropriate use of analgesics, and self-help techniques.
- Incorporate the appropriate use of osteopathic manipulative treatment to reduce pain and enhance function.
- Consider the role of cognitive-behavioral therapy as a means of education and for enhancing coping skills and prevention of pain in the elderly.
- Recognize the role of exercise targeted to the individual as a means of pain management to maintain and enhance functioning and avoid deconditioning.
- Consider the role of psychiatry or occupational therapy to avoid dysfunction, improve muscle strength, and aid in identifying the appropriate use of heat, cold, and massage therapy in the management of pain.
- Recognize that some older patients may be helped by other nonpharmacologic therapy such as acupuncture and transcutaneous electrical nerve stimulation.
- Appreciate the spiritual aspects of pain in the elderly and provide counseling or refer to a member of the clergy if appropriate.
Treatments – Non-Pharmacological

- Gentle massage
- TENS units (electro stimulation)
- Implanted nerve stimulators
- Hot baths or whirlpools
- Heat (15 to 20 minutes only)
- Cold (15 to 20 minutes only)
- Chiropractic
- Acupuncture
Treatments – Non-Pharmacological

- Ointments/creams (BenGay, BioFreeze, Tiger Balm, Salonpas (med. Patches), Aspercreme
- Slow movement
- Breathing techniques (slow, deep breathing), rest
- Music (some music, loud or soft, can make pain better or worse)
- Behavioral medicine
Treatments – Non-Pharmacological

- Glucosamine
- Arnica
- Biofeedback
- Energy healing
- Pilates
- Yoga
- Tai Chi
Treatments – Non-Pharmacological

- Visualizations and other diversional activities
- Acupressure
- Vocalizing (screaming and/or moaning)
- Other approaches:
  - Therapy
  - Surgery
Building an Institutional Commitment to Pain Management

- Develop an IDT work group
- Analyze current pain mgt. issues and practices
- Implement a standard for pain mgt.
- Establish policies and procedures
- Establish accountability for quality & monitor
- Provide information for pharm. & non-pharm. Mgt.
- Promise residents prompt response
- Provide education
RESOURCES

- www.painmed.org
- www.ampainsoc.org/advocacy/
- www.medqic.org
- www.consultdemi.net