PRINCIPLES OF PAIN MANAGEMENTAND ASSESSMENT WORKBOOK

RN/EEN/EN

Photo courtesy of Columbia University

PAIN ASSESSMENT AND MANAGEMENT
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For RN/EEN/EN

This project is funded by the Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care Program

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Acknowledgements

- In 2008 and 2009 St Paul de Chartres Residential Aged Care Community and five other high care facilities located in Victoria and Western Australia will collaborate with a highly expert nationwide research consortium led by the National Ageing Research Institute (NARI), to undertake a research project. In Queensland this project is supported by the Dementia Collaborative Research Centre - Consumers, Carers & Social Research (DCRC-CC&SR) at the Queensland University of Technology. This new project aims to address the urgent need to establish an effective and sustainable implementation strategy for pain assessment and management for the residential aged care setting and is funded by the Australian Government Department of Health and Ageing as part of the "Encouraging Best Practice in Residential Aged Care" (EBPRAC) program. The project is multifaceted and will include 1:1 on the job education and training aimed at improving the knowledge base of all staff in assessment and management of pain as well as the appointment and professional development of an expert in house "pain champion" nurse at each facility. The final phase of the project will address the issue of practicability and sustainability of the newly developed implementation approach and strategies throughout the residential aged care sector. Researchers from the DCRC-CC&SR will commence work with staff and residents at the facility in the coming weeks.

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Objectives

- After completion of this session attendees will be able to:
  - Discuss how to identify pain
  - State when pain assessments should be completed
  - Discuss what factors we are assessing when carrying out a pain assessment
  - Perform a RVBPI and/or ABBEY
  - Discuss communication of information
  - Discuss treatment options
    - pharmacological
    - Non – pharmacological

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PART 1 – PAIN WHAT IS IT?

Think about the last time that you had any pain.

What words would you use to describe that pain?

How did the pain impact on your day?

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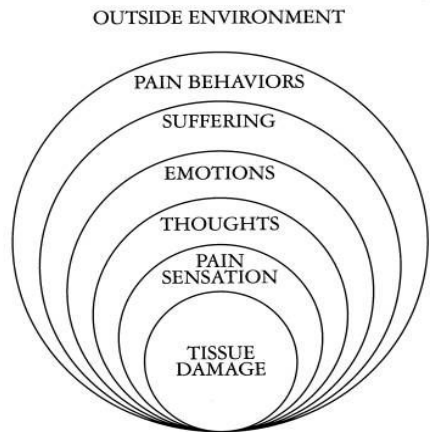
What is pain?

- *Definition*
  - *" It is an unpleasant sensory and emotional experience arising from actual or potential damage or described in terms of such damage"*

(IASP Subcommittee on Taxonomy . Pain 6 (3): 249 June 1979)



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What is pain?

WHAT DOES THIS MEAN

- It can't be measured
- Based on the individual's own feelings and interpretations of the pain and a combination of sensory, emotional and cognitive processes
- Influenced by beliefs, attitudes, personality

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PREVALENCE OF PAIN

- Significant number of residents in aged care are under treated for pain
- APS in 2005 Pain in Residential Aged Care: Management Strategies
    - 28 – 86% of nursing home residents have pain
- Why?

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Types of Pain

Three different ways to define types of pain

- Acute Pain vs Chronic Pain
  - Acute Pain – incident pain
    - Sudden
    - Related to acute injury or illness
    - Duration limited from days to weeks lessens with time
    - Obvious signs of pain
  - Chronic Pain – cancer/non – cancerous
    - Persistent > 3 months
    - Duration – months/years , unlimited
    - Assoc with depression, anxiety etc
- Aetiology – cancerous, ischaemic, postoperative
- Nociceptive/ Neuropathic/Psychological

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REFLECTION

- *Think about a resident or someone you know that has had a long term injury eg, back injury or arthritis.*
- *What do you notice about their activity levels? Do they change?*
- *Think about a time when you may have injured yourself, what did it feel like?*

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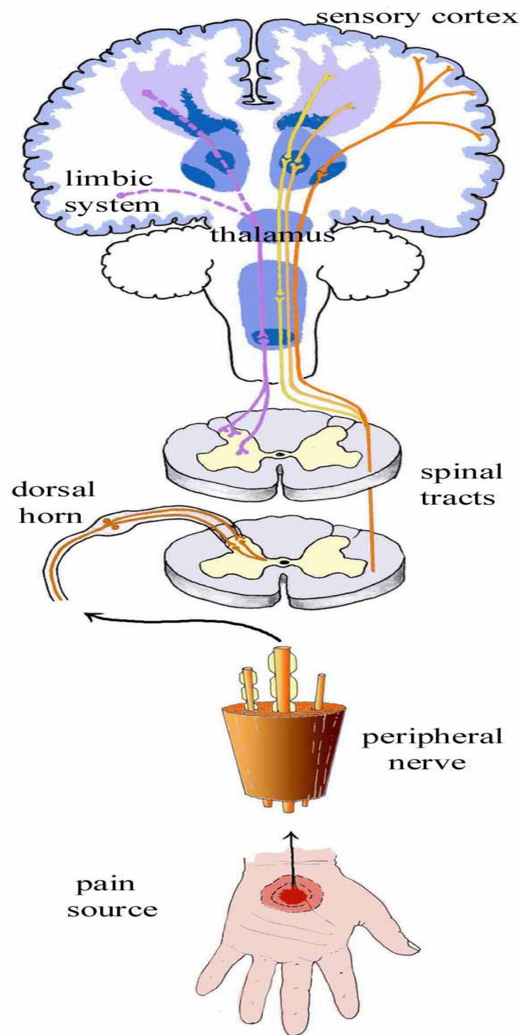
Pathophysiology of Pain



- Activation of peripheral receptors (transduction)
- Transmission to spinal cord
- Brain
- Modulation various levels of spinal cord and brain
- Perception of pain

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IMPACT OF PAIN

- Physical
  - stress response (acute) prolonged chronic pain syndromes
- Behavioural
  - Restless or agitated
  - Altered behaviours
- Social
  - Withdraw

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Impact of Pain cont……….

- Emotional/Psychological
  - Depression
  - Anxiety
  - Unhappy
  - Grumpy/Irritable

- Activity Levels
  - Altered sleep patterns
  - Decreased wanting to walk, attend ADL's

- Quality of life

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QUESTION

Some of these factors can impact on the experience of pain

- *What are some of the factors that may decrease the resident's tolerance of pain?*
- *What are some of the factors that may increase the resident's tolerance of pain?*

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PART 2 – PAIN ASSESSMENT

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Identification of Pain

- Ongoing process performed
    - On admission
    - Whenever change in resident condition
    - Whenever pain is suspected
    - Formally every 3 months

- Two step approach
  - Residents Verbal Report
  - Observation from Care Staff – rest/movement

- Use appropriate word – pain, soreness, tenderness, ache

- Use family members where possible

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REFLECTION

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- *Think of a resident who can verbally report pain. What would you like to know about the pain they are having?*

- *Think of a resident who has a cognitive deficit or dementia? What are some of the behavioural changes that we may look for that may indicate that they have pain?*

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PAIN ASSESSMENT GUIDE

- "WILDA"
- **W**ORDS TO DESCRIBE
- **I**NTENSITY
- **L**OCATION
- **D**URATION
- **A**GGRAVATING FACTORS

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PAIN ASSESSMENT GUIDE – Cognitive Deficits

"BODIES"

- Helps organise thoughts and report clearly to others

B – BEHAVIOURS

O – OCCURRENCE

D – DURATION

I – INTENSITY

E – EFFECTIVENESS

S – START/STOP

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PAIN ASSESSMENT

Once pain identified → comprehensive pain assessment

Includes:

- Medical History
- Psychosocial History
- Physical Exam
- Cause of pain
- Identify type of pain
- Impact of the pain on Life and Function

Pain Assessment

There are two multidimensional tools

- Modified Resident Verbal Brief Pain Inventory Scale (RVBPI)

- Tool for use with Resident with cognitive deficits
  - Abbey Pain Scale/PAINAD

(see handout).

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M- RVBPI tool

Verbal

- Quickest and easiest way to find out if someone is in pain
- Even residents with cognitive deficits may be able to say yes/no to a question asked
- Use different words
- Also observe resident

- RVBPI tool
  - Modified for use in residential care
  - Examines physical and psychosocial elements of the pain
  - Physically
    - Locality, intensity, effectiveness of medication
  - Psychosocially
    - Effect on sleep, movement, activities, mood, socialisation

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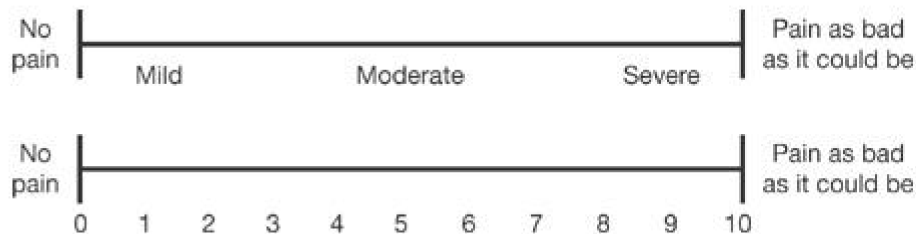
RVBPI – Other tools –unidimensional

To determine severity of pain and for ongoing monitoring and evaluation of treatment use other tools - unidimensional

- Numeric Rating Scale
  - " On a scale from 1 – 10 with one being no pain and 10 being the worst pain that you ever had, what is your



- Verbal Descriptor Scale

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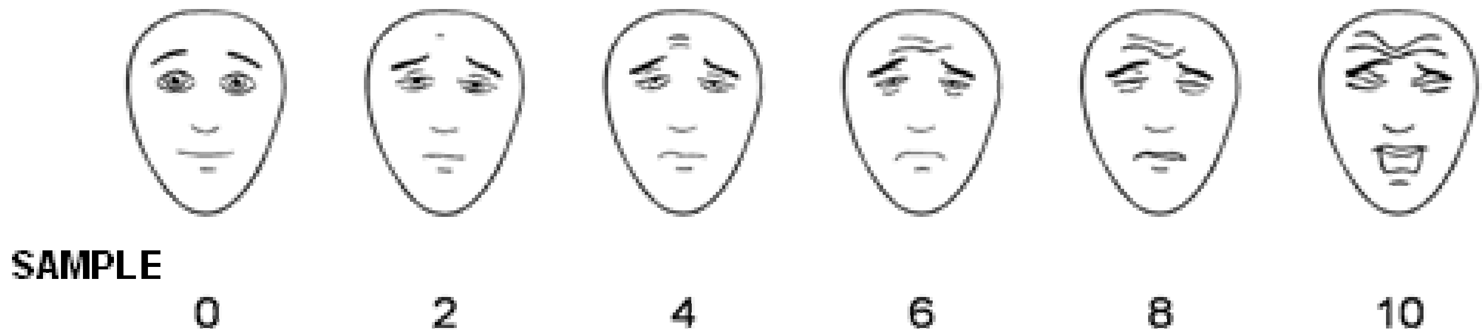
RVBPI unidimensional tools cont….

- Facial



http://www.iasp-pain.org/AM/Images//gifpainfacesscale.GIF

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Abbey – Pain Scale

- Created specifically for people with dementia
- Can be used for people without dementia
- Have knowledge of the resident's usual function
- Looks at 6 areas of pain related behaviour
- Uses terms such as absent, mild, moderate and severe
- Examine each area and then add all the scores together

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Abbey Pain Scale – cont

- Vocalisation
- Facial Expression
- Body Language/Movements
- Behavioural Changes
- Physiological Changes
- Physical Changes

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PAINAD tool

Pain Assessment IN Advanced Dementia (PAINAD)

Adapted with the permission of A.Hurley 2003 for Australia, by the Central Coast Dementia end stage/ palliative phase working group.

	0	1	2
Breathing Independent of vocalisation	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.
Negative Vocalisation	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frowning.	Facial grimacing.
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.

Directions for use of PAINAD

For each of the 5 rows determine a score of 0, 1 or 2 based on presenting behaviour. Write each score below and then a total (/10).

The score needs to be considered with reference to previous behaviour, recent events, known medical history, and medications administered.

If discomfort / pain is determined then document the action taken and evaluate the effectiveness of this.

DATE/ TIME	SCORE each row	ACTION TAKEN	EVALUATION
	+ + + + =		
	+ + + + =		
	+ + + + =		
	+ + + + =		
	+ + + + =		
	+ + + + =		
	+ + + + =		

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Barriers to Pain Assessments

- ***What are some of the barriers that stop a thorough pain assessment?***

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Barriers to Pain Assessment

- Cognitive Impairment
  - Dementia
  - Illness – confusion
- Communication problems – deaf, stroke
- Cultural/ Ethnic/Language
- Social Differences
- Personal Attitudes and Beliefs

  Eg. Pain is sign of weakness
- Workloads + fears of staff

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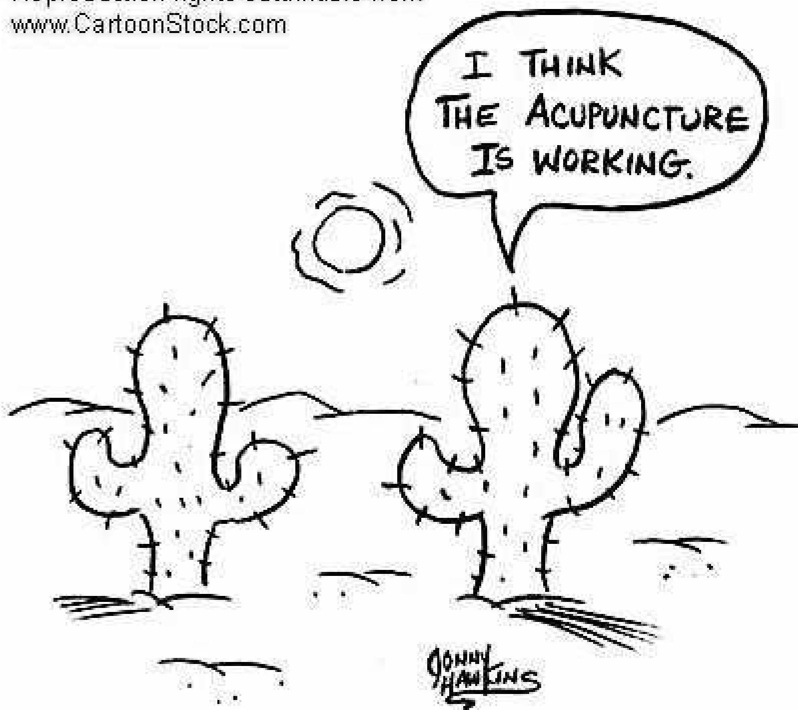
PART 3 – PAIN MANAGEMENT STRATEGIES



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Pain Management Treatment Options

- Pharmacological/Non – Pharmacological
- What is the treatment goal?
- Balance between both
- Co-morbidities
- Risk of Side Effects
- Need also to consider factors that affect the pain
  - Fatigue
  - Anxiety
  - Depression
  - Loneliness
  - Anger
  - Isolation

Sadness

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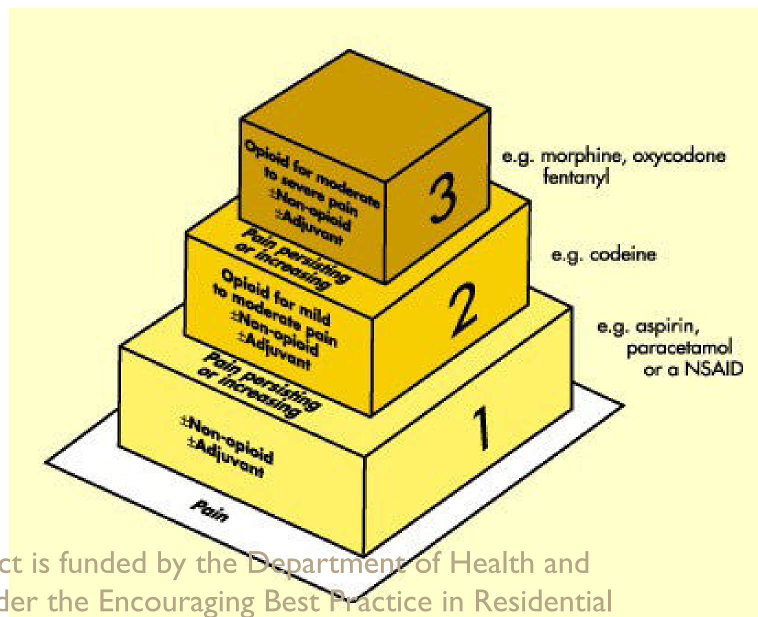
Pharmacological

- Tolerance and Regularity
- Tolerance – "start low go slow"
- Regularity
  - Round the clock dosing rather then prn – slow release
  - Short acting good for breakthrough pain or Incident pain
- WHO Ladder

  Pain relief



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Pharmacological

- Paracetamol
  - Max 4 g/day
  - Think about times given
  - Panadol Osteo – TDS Short/long acting components
- NSAIDs
  - Rarely used due to side effects
  - Brufen, Ibuprofen,
  - COX 2 inhibitors – Celebrex
- Paracetemol with Codiene
  - Good for incident pain – not good long term - SE

Pharmacology cont……..

- Opioids – short/long acting
  - Oral – tablets/liquids
  - Transdermal – Norspan, Durogesic
  - SC/IM/IV – Morphine, fentanyl
- Tramadol – use with caution
- Adjuvants
  - Anti- depressants - zoloft
  - Anticonvulsants (neuropathic pain) – epilim, lyrica

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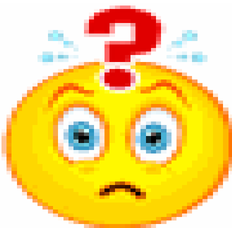
Principles of Pharmacologic management

- Initial analgesic choice will depend on severity of pain
  - 1-4 non – opioid
  - 5-6 non – opioid in conjunction with opioid
  - 7 – 10 non – opioid in conjunction with opioid
- Neuropathic pain – adjuvant
- Administer orally where possible, then transdermal avoid injections
- Administer around the clock rather then prn
- Use multi management strategies – medication + non – drug methods.

Principles of Pharmacological management

- Some side effects will occur – plan
- Addiction is rare
- Reassess pain management program effectiveness regularly (3 monthly).

QUESTION



- *What are some of the possible side effects of analgesia?*

"I think you'll find the side effects of this little drug rather amusing."

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SIDE EFFECTS

- Constipation
- Drowsiness
- Nausea
- Confusion
- Agitation
- Irritation - patches

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Management

- Constipation
  - Planning
  - Bowel management policy
  - Joanna Briggs : Best Practice Vol 12 Issue 7, 2008

  Management of Constipation in Older Adults
- Nausea
  - SE of morphine and derivatives, Norspan, Fentanyl
  - Resolves with 2 – 3 weeks
- Drowsiness
  - Resolves

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NON - Pharmacological

- Use in combination with medications
- Physiotherapy – Exercise
- Occupational Therapy
- Heat Therapy
- TENS
- Massage Therapy
- Manual Handling
- CAM – acupuncture, massage, chiropractic
- CBT

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ACFI

- Complex Health Care Need
  - Score 1, 3 or 6 depending on care needs and other resources used
- Funding for medications
- Need assessments
- Needs GP/ AHC input

DOHA: http://www.health.gov.au/acfi

THE MATRIX 1
Daily ACFI Funding

		CHC Rating (Q.11)	CHC Rating (Q.11)	CHC Rating (Q.11)	CHC Rating (Q.11)
Contribution of Complex Pain Mx (Q.12) to Complex Health Care Funding (CHC)	CHC Rating (Q.12)	A (no meds or self-meds)	B (2-7 day patch or oral meds >6'per day)	C (oral meds 6-11' per day)	D (daily s/c, IM, IV, or oral meds >11' per day)
None score 0	A	0	0	$13.15	$37.46
-therapeutic massage/heat packs- not complex (≥20', at least weekly) score 1 -therapeutic massage/TENS etc- by RN/AHP (≥20', at least weekly) score 3	B (1-4)	0	$13.15	$13.15	$37.46
-therapeutic massage/TENS etc- by AHP (at least 4x weekly) score 6	C (5-9)	$37.46	$37.46	$37.46	$54.09
-palliative care program involving end-of-life score 10	D (≥10)	$37.46	$54.09	$54.09	$54.09

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SUMMARY

- Identification and assessment using appropriate tools are important – RVBPI, ABBEY
- Pain impact on QOL, influencing other areas
- Devise appropriate pain management plan using both pharmacological and non – pharmacological combinations
- Manage Side Effects of pharmacological treatments

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QUESTIONS

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CASE STUDY

- Mrs B
- 90 year old lady – low care – 12 years
- Mobilizes with gutter frame
- Active – exercises twice a week, morning afternoon teas, hairdresser
- Family support
- Phx, AMI, angina, depression/anxiety, chronic pain - ? Misuse of opioid, spinal canal stenosis, # R ankle, multiple falls
- Distressed, cries, pain down left leg, hip and sometimes down right ankle – burning, left hip aches, pain across abdomen, sometime skin burns.

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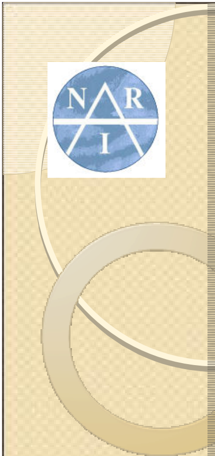

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