



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 identification and management of pain is important

Access to pain relief is a basic human right (White & Katz 2012; International Association for the Study of Pain 2010). It is estimated that 45–83 per cent of people in residential care experience at least one current pain problem (Goucke 2018). Older age and the presence of cognitive impairment increases the risk of pain being under recognised, under assessed and undertreated (Horgas, Laframboise-Otto, Aul & Yoon 2020; Podder 2019; Nguyen 2018; White & Katz 2012).

'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: 'is a distressing experience associated with actual or potential tissue damage with sensory, emotional, cognitive and social components' (Goucke 2018, p. 19).

Chronic or persistent pain: 'is pain that does not go away after the acute episode is over. It can also be defined by how long it lasts (more than 3+ months) or as being present after the body has normally healed after an injury' (Goucke 2018, p. 20).

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

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Brief standardised care process

Recognition and assessment

- Identify pain by asking and observing.
- Assess acute pain in residents to locate the source of the pain and provide symptomatic relief.
- Assess persistent pain across the following domains:
 - pain history and characteristics
 - physical, functional and psychosocial
 - effectiveness of current non-pharmacological and pharmacological pain interventions.
- Use validated pain tools/scales.

Interventions

- Acute pain:
 - Manage underlying cause
 - Relieve symptoms
- Chronic or persistent pain:
 - Non-pharmacological management
 - Physical therapies
 - Pharmacological management
- 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 the effects on pain within one hour of administering 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.
- Stay alert for signs and symptoms that indicate the presence of pain.

Resident involvement

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

Staff knowledge and education

- Educate staff to:
 - recognise that all residents, including those with dementia, may have pain
 - recognise that residents may use various words to describe 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

Ask the resident about their pain:

- on admission
- when their 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. Do a rapid pain assessment when the resident presents with acute pain or severe or moderate distress. The assessment should include the location, intensity, duration, quality and onset of the pain.

Chronic or persistent pain

The assessment of chronic or 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.

Where possible, use assessment approaches that include both self-report and observational measures.

Residents who can 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. It may help to use an observational tool for self-reporting.
- Offer self-report assessment tools in an accessible format (for example, simple language, large fonts, written and oral instructions, language other than English) and administer them using clear explanations.
- Help the resident communicate by providing sensory aids and a quiet, distraction-free environment.

Residents who are unable to verbally self-report

Use a combination of the following 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 (non-pharmacological, physical therapies and pharmacological).

Pain measurement tools/scales

- Use a multidimensional pain assessment tool, such as the Modified Residents Verbal Brief Pain Inventory (M-RVBPI), in the initial pain assessment.
- Once a suitable pain measurement tool has been identified, use the same tool for recurrent assessments to evaluate the effects of treatment.
- Assess pain at rest and on movement.

Suitable tools/scales include, but are not limited to:

- *Pain measurement tool (self-report):*
 - Numerical or visual analogue scales.
 - Use of 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)
 - Doloplus 2.



Review history

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

Pain characteristics

Assessment of the resident's pain characteristics should include:

- pain quality – the words the resident uses 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
- sites of pain – use a diagram/pain map to identify sites 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)
- report of pain or 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 their level of perceived control over the pain
- their knowledge and level of understanding about pain and pain management
- expectations of treatment
- impact on family/carers and other supports
- impact on social participation
- impact on pleasurable activities
- 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 treatment of the underlying cause.
- Offer symptomatic relief until the acute episode has resolved.

Chronic or persistent pain

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

Non-pharmacological interventions

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

Physical therapy should be prescribed 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.

Pharmacological therapies

- Anticipate, treat or avoid the side effects, drug interactions and contraindications of pain-relieving medicines.
- Administer analgesia on a regular basis ('around the clock') to maintain therapeutic levels.
- Give as needed (PRN) short-acting analgesia 30 minutes before an activity to help reduce predictable (incident) pain.
- Carefully manage any medication type, dose, route of administration, monitoring and adjustment 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.

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 the 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/carers.
- 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 a resident's pain, the use of pain assessment tools, non-pharmacological pain management strategies, the benefits of exercise, and medication use. Use suitable written material.
- 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 words ('sore', 'aching') to describe 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 education resources available from external health services, community palliative care, Program of Experience in the Palliative Approach (PEPA) and Palliative Care Regional consortia <<https://www.health.vic.gov.au/patient-care/palliative-care-consortia>>.



Evidence base

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Important note: This standardised care process (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 the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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