Clinical Solutions

A joint publication of the Illinois Health Care Association and CE Solutions

March 2017

Pain Assessment and Management in Long-Term Care

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Assessing and managing pain in the long term care setting (LTC) can be complicated by many variables, including whether the pain is acute or chronic, if the resident has been recently discharged from a hospital, or has a diagnosis of dementia. All of these impact the outcome to the resident.

Although pain is common among long term care residents, it is often under-reported, under-assessed and under-treated. The American Geriatrics Society (AGS) Panel on Persistent Pain in Older Persons estimated:

- 45-80 percent of long term care residents have substantial pain, and
- 25 percent of those with daily pain received neither analgesic medication nor nonpharmacologic treatment for their pain.

(AGS Panel on Pharmacological Management, 2009)

There is always so much for nurses to do and rarely enough staff to get it all done, leaving little time to do pain assessments. An interdisciplinary approach to regularly observing and assessing for pain should be part of each resident's care plan. The frequency of assessments and how to assess for pain will change depending on why the resident is at your facility and for how long as well as any changes in their health.

Before Admission
Receiving and reviewing every new resident's medications list before they arrive can help ensure pain medication is taken on schedule and in the correct dosage. When possible, get physician orders and prescribed medications from the pharmacy prior to admission. Otherwise, communicate with caregivers or the discharging facility that the resident should take medications before they are transported to your facility. Not doing this can mean a delayed or missing dose of pain medication due to time it will take to fill prescriptions at the facility after they arrive.

Admission After a Hospital Stay
Most skilled care admissions come from a hospital stay for an injury, surgery or acute illness. Make sure to ask hospital staff which medications the patient has been taking, when they last took each and when they are next due for each medication. If any medication is not readily available at your facility, ask hospital staff if the patient can be given medications before they leave the hospital. Otherwise, with no orders in hand, and no medications, it may take hours until the pharmacy can deliver medication.

Keep in mind that pain medication may have been reduced before discharge. A delay in transportation can mean missed medications. For example, a new

resident arriving at 4 p.m. may have been discharged from the hospital at 10 a.m. - with pain meds last taken early that morning.

Residents typically arrive with pain that had been managed until discharge. At the hospital, they were used to being frequently seen by a nurse. They likely had regular assessments for pain and should be familiar with describing it.

Admission for Short-Term Rehab
New residents admitted for rehab after an injury or illness were used to having their pain medications administered on a schedule. When arriving at a facility for rehab, pain medication is often given p.r.n. Because they have not been used to asking for pain medication, they don't. They may think, "It's fine, I don't want to bother anyone."

Proper pain management can ensure more effective rehab. Monitor and assess these residents to determine how much pain medication they need and when they need it. Time pain medication so they can participate and be effective in therapy. It may be beneficial to get them on a schedule that has them taking the medication before rehab.

While they are in rehab, regular assessments for pain are necessary. Because they are more active in rehab, they could experience more pain issues. As the resident heals and is ready to go home, they may need to be weaned off pain medication.

Admission from Home to Assisted Living
New residents arriving after living on their own may have improperly managed pain. Many do not take medications correctly - too much, not enough or not at all. They may have prescriptions from multiple physicians and pharmacies. Some prescriptions may have stopped being effective.

Upon admission, do a medication review, noting any pain medications and the dosages. Do not rely on the new resident to precisely remember what they had been taking. People living on their own often take more medication, including over-the-counter drugs, than can be given in the facility. If guidelines do not allow you to administer the amount and combination of pain medications that they were taking at home, work with the physician and pharmacy to manage their pain.

These new residents may also be unfamiliar with talking about their pain. Using other words can aid residents in describing how they are feeling: burning, aching, soreness, tightness, discomfort or throbbing.

Recognition and Assessment of Pain
There is a tendency in the elderly patient to not self-report pain. An accurate pain assessment considers the age of the patient, past medical history and cognitive status. Pain may be both acute and chronic in nature. There may also be multiple sources of pain.

Sources of pain in the elderly can include:

- Degenerative joint disease
- Spinal stenosis
- Fractures
- Pressure ulcers
- Neuropathic pain
- Urinary retention
- Post-stroke syndrome
- Fibromyalgia
- Cancer pain
- Contractures
- Postherpetic neuralgia

- Oral/dental sources
- Constipation
- Improper positioning

(Shah, n.d.)

There are many simple assessment tools for residents to rate the intensity of their pain. A numeric rating scale (NRS) asks patients to rate pain from 0 (no pain) to 10 (worst possible pain). Another tool is to use visual symbols indicating the degree of pain such as the Wong-Baker FACES® Pain Rating Scale. Using a visual analog scale (VAS) for pain, patients are asked to note their pain intensity - such as placing a line on the scale -- between two verbal descriptors, e.g., no pain and worst possible pain. Then a ruler is used to measure the distance between no pain and the patient's line.

Residents with dementia may be unable to report pain and request pain medication. Dementia also makes it difficult to assess the effectiveness of pain medication.

Non-Specific Signs and Symptoms of Pain
The key to an effective pain management intervention is to have the entire interdisciplinary team involved in the assessment, monitoring and treatment. All direct care staff must be able to identify indicators of pain. Pay particular attention to the non-specific signs and symptoms that may suggest the presence of pain:

- Bracing, guarding, rubbing
- Change in behavior
- Change in gait
- Decreased activity levels
- Eating or sleeping poorly
- Fidgeting, increasing or recurring restlessness
- Frowning, grimacing, fearful facial expressions, grinding of teeth
- Loss of function
- Resisting certain movements during care
- Sighing, groaning, crying, breathing heavily
- Striking out, increasing or recurring agitation

(NGC, 2016)

Each resident needs to be observed during rest as well as in activity to assess the level of pain and how it is affecting daily functioning and activity. For example, if a resident suddenly stops participating in activities at the same level, they may be experiencing new pain or pain that is no longer being controlled. A dietary aide may notice that a resident does not eat as well at breakfast or lunch because of pain that is not under control and may distract the resident from eating.

Sleep pattern is another important factor: pain may impact the ability to gain an adequate night of sleep. The presence of anxiety or depression may also be a factor in the pain; chronic pain can be a contributor to both conditions.

Treatment
When pain is confirmed or reported, assess the key characteristics of the pain to get a full assessment: location, intensity, quality, onset, duration and exacerbating and alleviating features. Questions related to alleviating features should include a thorough analgesic history and the effects of past treatments. (Hanks-Bell, 2004)

When considering the appropriate treatment for the diagnosed pain include nonpharmacologic and pharmacologic approaches to pain management. Take the time to fully research the treatment history for effectiveness or need for alternative therapies.

Nonpharmacologic interventions include exercise, pain education, heat, cold, massage therapy, physical therapy, occupational therapy, acupuncture, transcutaneous nerve stimulation (TENS), relaxation and distraction.

For example, a study presented in November 2016 by researchers at Hospital for Special Surgery in New York City found that low-impact exercise helped decrease pain. Of the participants -- mostly Chinese women between the ages of 60 and 79 - 84 percent reported less pain after the study's eight-week exercise classes (Motivation to Move Study, 2016). Another study found that an eight-week mindfulness meditation program helped to reduce severe chronic low back pain in older adults (Mindfulness Study, 2016).

Pharmacologic interventions include:

- Non-opioid analgesics, such as acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), cyclooxygenase-2 (COX-2) inhibitors and tramadol.
- Opioid analgesics (morphine, oxycodone, hydromorphone, hydrocodone, oxymorphone, tapentadol, methadone, fentanyl patch, non-topical fentanyl formulations)
- Topical analgesics (counterirritants, capsaicin, topical diclofenac, lidocaine patch)
- Medications for neuropathic pain (anticonvulsants, secondary amine tricyclic antidepressants, selective serotonin and norepinephrine reuptake inhibitors) (NGC, 2016)

The effectiveness of any treatment and response must be routinely assessed and documented, including assessment of any adverse consequences.

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