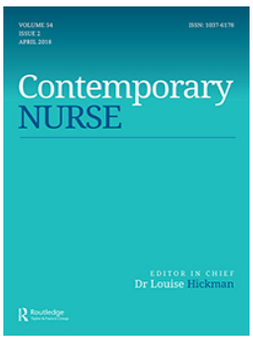

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The complexity of pain in aged care

Helen Holloway [a*], Deborah Parker [a,b] and Helen McCutcheon [a]

[a]*School of Nursing, Midwifery and Social Work, Faculty of Health and Behavioural Science, University of Queensland, St Lucia, Queensland, Australia;* [b]*Faculty of Health, University of Technology Sydney, Sydney, Australia*

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Older people living in residential aged care often experience complex persistent pain because of the presence of multiple comorbidities and geriatric syndrome. Complex persistent pain is associated with physical, psychological and emotional burdens. All of these factors can result in existential suffering. Current pain management in aged care is targeted at passive strategies. More consideration needs to be given to how assessment and management of pain in this population can be improved, using a biopsychosocial model, to decrease unnecessary suffering.

Keywords: pain; aged care; pain management; comorbidities

Introduction

In 2011, '169,000 people lived in Residential Aged Care (RAC), 77% were aged over 80' (Australian Institute of Health and Welfare, 2012, p. 22). Ageing is associated with increased disease burden, disability and frailty and as a result individuals living in RAC have higher incidence of multiple health conditions and geriatric syndrome. Complex clinical management is often required (Australian Institute of Health and Welfare, 2012; Hillen, Vitry, & Caughey, 2017). Multiple comorbidities often mean persistent pain which by its very nature is complex (Bendelow, 2013). In RAC, this pain is often poorly identified, assessed and managed, which impacts further on an older person's health, disability and quality of life. Primary strategies for the management of pain in RAC are focussed on a biomedical model of pain management, involving passive strategies. These include pharmacotherapy and/or non-pharmacological interventions. It is well documented that active strategies used within a biopsychosocial model are more beneficial for the management of persistent pain (Goucke, 2018; painaustralia, 2017).

Multiple comorbidities

Older people living in RAC do so because of deteriorating health and increased disability and frailty, often due to the presence of multiple long-term comorbidities and geriatric syndrome (Hillen et al., 2017). The most common diseases experienced by older people living in RAC include cardiovascular, musculoskeletal, cerebrovascular, endocrinological, neurological,

*Corresponding author. Email: helen.holloway@uq.net.au

respiratory, cancer, psychological or injuries related to falls (Australian Institute of Health and Welfare, 2016; Hillen et al., 2017). They will have at least one of these diseases, but is more likely they are living with three or more of these conditions (Caughey, Vitry, Gilbert, & Roughead, 2008).

Disability and frailty can also be contributed to by the presence of 'geriatric syndrome', a collection of factors that cannot be identified within a specific disease state, but add to morbidity and the need for care (Hillen et al., 2017). Although not an exhaustive list it includes 'incontinence, dementia, delirium, falls, pressure ulcers, visual and auditory sensory impairment, sarcopenia, malnutrition, frailty, immobility, gait disturbances and depression' (Won et al., 2013, p. 338). The presence of multiple chronic comorbidities and geriatric syndrome increases the prevalence of persistent multifocal pain. Hillen et al. (2017, p. E18) report that pain was the second most prevalent 'other' condition included on the Aged Care Funding Instrument (ACFI) and has been estimated to be as high as 80% in this population (Commonwealth of Australia, 2012; painaustralia, 2017; Veal, Bereznicki, Thompson, & Peterson, 2014).

Persistent pain

Persistent pain is complex and is a subjective individual experience that can be influenced by many factors (Garland, 2012). These could be an individual's anatomy, physiology or a complex array of other factors such as age, sex, cultural and ethnic background, coping skills, attitudes, emotions, social skills, mental health, education level, spiritual beliefs or life experiences. All these may impact on an individual's interpretation of the pain experience, reporting and how they respond to management strategies (Asmundson & Wright, 2004; Cope, 2010; Kumar & Allcock, 2008).

For an older person, aged related changes in the peripheral and central nervous system, including the expression of neurotransmitters and receptors, mean the detection, processing and perception of nociceptive and neuropathic information are altered (Molton & Terrill, 2014; Yezierski, 2012). These age-related neurological changes interact with neurological changes that occur as a result of persistent pain, the consequences of which may be altered pain sensitivity and experience of pain in chronic disease states (Cole, Farrell, Gibson, & Egan, 2010; Molton & Terrill, 2014). Chronic disease alone has been known to impact on an older person's psychological and emotional well-being and quality of life (Megari, 2013). The presence of persistent pain is known to result in depression, anxiety, fatigue, altered sleep patterns, nutrition, activity and socialisation. All of these factors together contribute to further cyclical functional, psychological and emotional decline (Dahan, van Velzen, & Niesters, 2014; Molton & Terrill, 2014).

Ageing, chronic illness, persistent pain, disability, frailty and living in RAC can mean a loss of identity, family role, social supports, independence and result in loneliness (Dahlberg & McKee, 2014). Given the nature of reasons for admission to RAC, the presence of existential pain and suffering cannot be overlooked. Existential suffering/pain can be the result of loss, anguish and bitterness that is experienced both at a psychological and spiritual level and often becomes evident once physical pain is managed (Mackinlay, 2012). Whilst this pain has been described in terms of palliative care, older people living in RAC with chronic comorbidities may experience it because of increased dependence and frailty.

Pain assessment and management

More attention is being paid nationally and internationally to pain assessment and management in older people (particularly those with dementia). Over the last 25 years, it has been identified that the under recognition and management of pain is a significant issue in RAC (Charette & Ferrell,

2011; Cunningham, McClean, & Kelly, 2010; Goucke, 2018; Hadjistavropoulos et al., 2016; Herr, Coyne, McCaffery, Manworren, & Merkel, 2011b; Husebo et al., 2012). However, despite an increased focus on pain assessment and management, the production of clinical guidelines and assessment tools, and an increase in education, poor assessment and management practices persist (Herr, 2011a; Lukas et al., 2013).

The lack of assessment and management in this population has been attributed to a multifaceted combination of resident, staff, facility and aged care system barriers, which has been well documented (Achterberg et al., 2013; Bruneau, 2014; Goucke, 2018; Kaasalainen et al., 2010; Savvas & Gibson, 2015). Other factors include lack of significant scientific research covering pain and the older person, pain in people with dementia or older people with comorbidities and polypharmacy, the use of analgesic and adjuvant pharmacological therapy in the older person and people with dementia and validation of all assessment tools (Achterberg et al., 2013; Bruneau, 2014; Savvas & Gibson, 2015). The continual poor recognition and treatment of pain, in the older person living in RAC, contributes to the complexity of pain, disability and frailty for these individuals.

The current management of pain in RAC is guided by the ACFI, where the strategies for management are passive strategies, based on a biomedical model targeted at medication management and the use of non-pharmacological strategies such as massage, Transcutaneous, Electrical Nerve Stimulation and heat packs (Commonwealth of Australia., 2012; painaustralia, 2017). This biomedical model of pain management does not address the complex nature of persistent pain or existential pain that may be experienced by the older person living in RAC (Goucke, 2018; painaustralia, 2017).

What is required is a biopsychosocial approach where multiple strategies are utilised as part of the plan of care. This approach requires a comprehensive assessment that involves not only the utilisation of verbal or non-verbal observational tools, but considers the residents history, comorbidities, medications, mood, quality of life, requires a physical assessment (conducted at rest and on movement) and assessment of the pain (what is the pain like, where is it, radiation, etc.) (Goucke, 2018; Kaye, Baluch, & Scott, 2010). Management strategies need to be person centred utilising pharmacological and non-pharmacological strategies, which include active and passive physical strategies, psychological, emotional and spiritual support (Kaye et al., 2010; Makris, Abrams, Gurland, & Reid, 2014; painaustralia, 2017; Savvas & Gibson, 2015). A good document for the discussion of the assessment and management of pain in RAC is the Australian Pain Societies: Pain in Residential Aged Care Facilities: Management Strategies, which outlines best practice strategies specifically for aged care. A second and updated edition of this publication has recently been released (Goucke, 2018).

Impact statement

Persistent pain, multiple comorbidities and geriatric syndrome contribute to frailty, disability and impaired quality of life for the older person in RAC. Inadequate pain assessment and management of these complex pain situations result in unnecessary suffering for the older person. More consideration needs to be given to addressing best practice pain assessment and management care and research in this population.

Conclusion

Multiple chronic diseases, geriatric syndrome and psychosocial, emotional and spiritual factors, mean that older people living in RAC will most likely experience complex persistent pain. Current management strategies are targeted at addressing the physical experience of pain only. There is an urgent need to increase our knowledge in management of complex persistent pain

in the older person living in RAC and to decrease disability, unnecessary suffering, inappropriate or inadequate management and improve quality of life for all individuals.

ORCID

Helen Holloway http://orcid.org/0000-0003-3274-2095
Deborah Parker http://orcid.org/0000-0003-2552-8613
Helen McCutcheon http://orcid.org/0000-0002-4654-2839

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