

Section 17

Pain CAP

Problem

Pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage.” It is a subjective experience, and “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” (International Association for the Study of Pain — IASP).

Pain can be affected by damage to various physiologic systems and tissues, including musculoskeletal (for example, arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (for example, diabetic neuropathy, herpes zoster), and cancer. The intensity (severity) of the pain is a subjective matter and is not necessarily proportional to the type or extent of tissue or system damage.

Among the relevant issues assessed in the Pain CAP are the newness of the pain, the intensity of the pain, the nature of current treatments, and the extent to which self-reported pain is hindered by cognitive or communication deficits.

The presence of pain can also increase suffering in other areas, leading to an increased sense of helplessness, anxiety, depression, decreased activity, decreased appetite, and disrupted sleep. Management of pain thus extends beyond analgesia to include other interventions and treatments focusing on the person’s quality of life and ability to function.

Pain must be managed in a timely fashion, especially if it is of recent onset. Pain management should involve an interdisciplinary approach, working with the person and his or her family or caregiver. Additionally, to be effective, the informal caregivers and the person must communicate the signs and symptoms of pain in a timely manner to the physician and other members of the care team.

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Overall Goals of Care

- Identify and treat underlying reasons for pain.
- Optimize the ability to perform activities of daily living and to live an active social life.
- Relieve suffering.
- Monitor treatment efficacy and adverse effects.
- Recognize the association of pain and other issues, such as depression, withdrawal, and functional decline. Pain management should be viewed as part of a larger objective promoting physical activity and quality of life.

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Pain CAP Trigger

This CAP applies to long-term care, home care, assisted living, post-acute care, and community health assessment. The goal of this CAP is to assess and manage pain and the problems it causes in a timely fashion.

This CAP triggers two groups of persons for specialized follow-up, based on the severity of the reported pain rather than the likelihood of curing the pain. In fact, it is relatively uncommon that a person in either triggered group will be fully cured. Thus, the key goal of this CAP is to improve the person's general status.

HIGH RISK TRIGGER A person with severe, horrible, or excruciating pain (whether the pain occurs daily or less frequently). This group includes about 5% of persons in long-term care facilities, 25% of home care recipients, and 4% of older adults living independently in the community. In a long-term care facility setting, about 45% of the persons triggered into this group will improve over a 90-day period, and 15% will become pain free. The rate of improvement in home care is about 15%, while the proportion becoming pain free is only about 5%.

MEDIUM RISK TRIGGER A person with daily pain described as mild or moderate. This group includes about 12% of persons in long-term care facilities, 25% of home care recipients, and 15% of older adults living independently in the community. In a long-term care facility setting, about 35% of the persons triggered into this group will improve over a 90-day period, and 15% will become pain free. The rate of improvement in home care is about 14%, while the proportion becoming pain free again is about 7%.

NOT TRIGGERED All other persons.

Pain CAP Guidelines

Further Assessment of Pain

Pain frequency and intensity. To manage pain, a thorough assessment includes the following:

1. taking a detailed history of pain intensity, location, frequency, and characteristics;
2. completing an accurate physical examination;
3. carrying out proper laboratory studies;
4. deciding the extent to which the pain affects emotional status and preferences;
5. observing the performance of the person; and
6. reviewing present interventions and assessing their efficacy and side effects, if any.

Additional considerations in assessing pain:

- Do not assume that changes in pain patterns or new pain are caused by pre-existing conditions. A new, thorough evaluation should be carried out each time there is new pain or a change in the pattern of existing pain.

- As pain is common in older adults and persons living with chronic illness, pain should be treated as the fifth vital sign and, as such, monitored on a regular and scheduled basis.
- After the assessment with an interRAI instrument, follow up by asking the person to grade the pain severity using a supplemental pain assessment tool the person finds easy to use (examples are provided in the text that follows). Include the person's estimate of pain intensity at its lowest and highest levels. Questions should be simple and concrete, and the person's statements about pain should be taken at face value. If the person does not understand, use simpler or different words. Use the interRAI pain questions regularly, as well as any supplemental tools, to check pain symptoms over time. Record findings on a pain flow sheet to assess the efficacy of interventions. Examples of supplemental pain assessment tools include the visual analog scale (person places a mark on a 10 cm line in accordance to severity); a numerical rating scale (how bad the pain is on a scale of 0, no pain, to 10, worst possible pain); the verbal descriptive scale (mild, moderate, severe, horrible, excruciating); and the faces pain scale (showing faces from a smiling one to a face in extreme agony). There are also specialized pain assessment tools for persons with difficulties in verbalization.
- For persons on an analgesic, a routine pain reassessment is recommended. This will help you titrate the analgesic as necessary.

Observe frequency and intensity of pain. To manage pain adequately, continuing observation of the person's performance is important. If the person cannot communicate verbally, lacks the ability to describe symptoms, or tends not to complain, observation is the only way to assess pain.

You should be sensitive to cultural factors that may affect the manifestation of pain. For some cultural groups, a tendency toward stoicism may hinder the person's willingness to express pain. On the other hand, there may be a tendency for staff or informal caregivers to inappropriately discount pain indicators among persons who are more expressive about health concerns than expected based on cultural norms.

Use observations during usual activities (for example, morning care, physical therapy) to establish or confirm the person's pain complaints/signs of pain, and correlate this with changes in physical functioning. Speak with those providing direct care, including family members, and document the observations of these individuals.

Nonverbal signs of pain:

- facial expressions (for example, frowning, grimacing)
- vocal behaviors (for example, sighing, moaning)
- body position (for example, guarding, distorted posture, restricted limb movement, increased resting)
- change in routine (for example, staying in bed, less or slowed involvement in activities of daily living, decreased intake of food and fluids)
- change in mental status (for example, irritability, confusion)
- signs of aggression

Determine pain location, type, and response to external conditions. Determine as precisely as possible where the person feels pain. Where the pain is located can be of

importance when the care plan is developed (for example, pain related to peripheral vascular disease or arthritis will affect the care planning interventions).

- Find out if the pain is constant, changes over time, or comes and goes (intermittent). If intermittent, ask about its frequency, duration, and the circumstances in which it occurs. The person's pain experience may vary by site, time of day, and activity.
- Ask the person to describe what the pain feels like. Ask: "What words best describe it?" Descriptions may be helpful in guiding therapy and in finding out whether the pain is more likely neuropathic (burning, pins and needles, shooting, numbness), musculoskeletal (cramping, crushing, throbbing, stabbing), or visceral (cramping, tightness).
- Ask what makes the pain better or worse (for example, moving, sitting still, staying in the same position, following medication administration, maintaining drug schedule, taking medication as pain arises). Has the pain subsided as hoped following the implementation of a planned analgesic drug program? Note what behavior seems to relieve the pain and what makes it worse.

All information from this discussion must be correlated to findings from the physical examination and proper laboratory data.

Assess treatment preferences. Discuss treatment choices with the person (and family as appropriate) and ask about preferences and expectations. Respecting preferences promotes adherence to a regimen and achievement of therapeutic goals. For example, it is not uncommon for terminally ill persons, preparing for end of life, to prefer experiencing some pain rather than taking doses of medication that result in a diminished level of alertness.

Management of Pain

Pharmacological Intervention

Consider whether the person prefers to be (or should be) referred to a pain clinic or pain outreach team. The treating physician usually prescribes a drug therapy after identifying new pain or an acute flare-up of chronic pain. A person may be in daily pain for long periods without a drug regimen being prescribed, but this must not be permitted to occur. Before starting a new medication, identify and review all medications the person is taking, including over-the-counter medications, alternative medications, and herbal remedies. It is also important to set a specific pain improvement goal, responding to the person's desired comfort level within a specified time period.

The physician does not always have the same opportunity as other clinical staff (for example, nurses) or family members to monitor the results of the intervention on the person's everyday life. Therefore, the nurses and family members are in a key position to interview the person and observe the impact of new medications. The person and the nearest caregivers should be aware of what pain medication has been started and the strength of its effect (where it stands on the analgesic ladder introduced by the World Health Organization [WHO]; (see box on next page), how soon the medication can be expected to show its effect, and what adverse effects to monitor. [See Appropriate Medications CAP.]

Drug therapy is a mainstay for managing pain. Adhere to these basic concepts of treatment:

- By mouth is the most convenient and cost-effective route of administration.
- By the clock involves around-the-clock administration, rather than as needed, and allows each analgesic dose to achieve constant pain control. However, for control of severe pain, self-administered pain medication (for example, a patient-controlled morphine pump) often results in more acceptable levels of pain control with lower use of the analgesic.
- By the ladder administration is modified from the WHO Three-Step Analgesic Ladder (see box on next page). Note that in addition to traditional analgesic medications, several other types of pharmaceuticals have pain-relieving effects. Consider consulting the physician about how to improve pain management by elevating the pain threshold (that is, the point at which a person is uncomfortable with his or her pain) with the use of antidepressants or managing neuropathic pain.
- Choose the best single analgesic for the person, then titrate the dose up or down as necessary. Side effects are easier to identify if only one drug is initially provided. At the same time, choosing the single best analgesic may be quite difficult. Many pharmaceutical agents are now being co-formulated to better control pain (the key for breakthrough pain is to prescribe very rapidly available substances).
- Increase the drug dose or strength (in the case of opioids) when there is inadequate pain control. Often, an additional one-third of the present dose of opioid is added to control breakthrough pain.
- Prevent and treat analgesic side effects. Precautions must be taken with some medications to control unwanted side effects (WHO Ladder — see box). Side effects are more likely to occur in older and frailer persons with adverse effects often arising from changes in the central nervous system (for example, delirium, restlessness, sleepiness). Other common symptoms are gastrointestinal (for example, nausea, vomiting, stomach irritation, constipation).

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Adapted from the WHO LADDER for Chronic Pain

For mild to moderate pain:

Step 1: “nonopioids”: Paracetamol/Acetaminophen, aspirin, or other nonsteroidal anti-inflammatory drugs (NSAIDs — **Note:** While this is in the WHO approach, many geriatric pain experts might take NSAIDs off this list considering their potential for side effects, including GI, renal, delirium); start ulcer prophylaxis.

If moderate pain remains unrelieved by Step 1 drugs:

Step 2: “weak” opioids; start laxatives (unless contraindicated).

For moderate to severe pain unrelieved by Step 2 drugs:

Step 3: “strong” opioids; start laxatives (unless contraindicated), consider medications for nausea, if needed. **Note:** The distinction between weak and strong opioids, although still widely used, is not state of

the art. Strong opioids at Step 3 are now commonly classified as Step 2 level agents, exactly as the “weak” opioids, because they are co-formulated at very low dosages with other agents.

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Nonpharmacological Intervention

Nonpharmacological approaches are important in pain management because they

- ☐ may augment the efficacy of medications
- ☐ usually have minimal adverse effects
- ☐ give the person and family a sense of participation and control
- ☐ may address functional decline, mood, and social isolation

Educate the person, family, and direct care staff.

- ☐ Dispel myths that pain and disability are normal parts of aging.
- ☐ Discuss the cause of the pain, pain assessment findings, goals of treatment, multidisciplinary plan of care, prognosis, treatment options, and side effects.

Consider the following approaches:

- ☐ Physical, occupational, and other therapies to help with safety assessment (for example, falls, injuries), immobilization of a joint, strength and endurance training, and other pain management techniques.
- ☐ Physical modalities (for example, heat, ice, or massage).
- ☐ Relaxation and distraction techniques (for example, individual, group, or one-on-one activities, such as meditation, music, conversation, or audio books).
- ☐ Other options include acupuncture, tai chi, and other complementary therapies.
- ☐ Help the person set realistic and concrete goals (for example, walk 100 feet, go to an activity three times a week).
- ☐ Consider whether the person needs added psychological and social support.

Prevention of Unwanted Consequences of Pain

- ☐ Special attention should be paid to the relationship between pain and functional capacity. [See ADL CAP.]
- ☐ Special attention should be given to the relationship between pain and depression. Persons in chronic pain tend to develop depression, and therefore they should always be assessed for depression. [See Mood CAP, specifically Depression Rating Scale, and remember that the relationship between pain and depression is bi-directional.]
- ☐ Active management of underlying and accompanying diseases.

- To prevent other negative consequences of pain, see Behavior CAP and Social Relationship CAP.

Additional Resources

- American Geriatric Society Panel on Chronic Pain in Older Persons.** 1998. The management of chronic pain in older persons. *JAGS* 46(5): 635–51.
- Bair MJ, Robinson RL, Katon W, Kroenke K.** 2003. Depression and pain comorbidity. *Arch Intern Med* 163: 2433–45.
- Bernabei R, Gambassi G, Lapane K, et al.** 1998. Management of pain in elderly persons with cancer. *JAMA* 279(23): 1877–82. **Note:** This paper describes the prevalence and predictors of daily cancer pain and analgesic treatment using MDS pain and drug data from five states. Findings: 26% of persons in pain received no treatment; others were inadequately treated, especially older and minority persons.
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- Scherder E, Oosterman J, Swaab D, Herr K, Ooms M, Ribbe M, Sergeant J, Pickering G, Benedetti F.** 2005. Recent developments in pain in dementia. *BMJ* 330: 461–64.
- Stolee P, Hillier LM, Esbaugh J, Bol McKellar L, Gauthier N.** 2005. Instruments for the assessment of pain in older persons with cognitive impairment. *JAGS* 53: 319–26.
- Zyzzkowska J, Szczerbińska K, Jantzi MR, Hirdes JP.** 2007. Pain among the oldest old in community and institutions. *Pain* 129(1-2): 167–76. Epub 2007, January 23.

Clinical Practice Guidelines, Manuals, and Web Sites

- American Pain Society.** A multidisciplinary educational and scientific organization serving people in pain by advancing research, education, treatment, and professional practice. www.ampainsoc.org
- City of Hope Pain Resource Center.** Serves as a clearinghouse to disseminate resources to help institutions improve pain management. Over 300 materials can be found on this site. <http://prc.coh.org>
- Griffie J, Matson S, Muchka S, Weissman D.** 1998. Improving pain in the long-term care setting: A resource guide for institutional change. Medical College of Wisconsin, Milwaukee, WI. Division of Hematology/Oncology, 9200 W. Wisconsin Ave., Milwaukee, WI 53226. (414) 805-4605.
- Griffie J, Muchka S, Weissman D.** 2000. Nursing staff education resource manual: Pain management 101: A six session in-service education program in pain management for long-term care facilities. Medical College of Wisconsin, Milwaukee, WI. Division of Hematology/Oncology, 9200 W. Wisconsin Ave., Milwaukee, WI 53226. (414) 805-4605.
- International Association for the Study of Pain:** www.iasp-pain.org
- McCaffery M, Pasero C.** 1999. *Pain: Clinical manual*. St. Louis, MO: C.V. Mosby.
- Palliative Medicine Program at the Medical College of Wisconsin.** Develops, implements, and disseminates innovative educational and clinical care programs. This Web site offers resource materials, analgesic guidelines, and information on institutional pain management. www.mcw.edu/pallmed

Rochon T, Patry G, DeSilva D. 2001. *Pain relief resource manual*. Brown University Center for Gerontology and Health Care Research, Providence, RI. (401) 863-9628.

U.S. Department of Health and Human Services. 1992. *Clinical practice guidelines: Acute pain management*. (AHCPR Publication No. 92-0032). Washington, DC: U.S. Government Printing Office. (Also available online at www.nlm.nih.gov)

U.S. Department of Health and Human Services. 1994. *Clinical practice guidelines: Management of cancer pain*. (AHCPR Publication No. 94-0592). Washington, DC: U.S. Government Printing Office. (Also available online at www.nlm.nih.gov)

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