Basic Pain Assessment & Management of the Older Adult in Residential Care

Site Applicability

All VCH Residential Care Sites

Practice Level

Basic skills for the following professions (within their respective scope of practice):

- NP, RN, RPN, LPN
- Dietitian (RD)
- OT
- PT
- SW
- Pharmacist
- Recreation Therapist

Basic skills for Health Care Workers, (HCW/RCA's), Rehab assistants, Activity Workers

Policy Statement

- Pain, aches, discomforts are to be assessed for each resident on admission, quarterly, and when there is a significant change in condition.
- An interdisciplinary approach to promote comfort is to be initiated, in consultation with the resident or supports (family and friends).
- Both non-pharmacological and pharmacological interventions should be incorporated into this plan of care.
- If pain is suspected to be the cause of a person's behaviour, an analgesic trial is to be initiated that follows the Analgesic Steps adapted for Residential Care. (Appendix B)
- Pain/discomfort levels should be monitored until the resident's comfort goals are achieved ensuring there is clear documentation to facilitate resident centered treatments and clear communication between health care clinicians.

Need to Know

Guiding Principles (refer to Decision Tree – Appendix C)

- All persons have the right to the best possible pain relief
- Any pain complaint that affects physical function or quality of life should be recognized as a significant problem
- Pain is a symptom and underlying causes need to be investigated and appropriately treated. Pain should be assessed when there is a change in the resident's behaviour.
- Interdisciplinary team members are professionally and ethically obligated to advocate for change in the treatment plan when pain relief is inadequate.
- Pain is a subjective, multidimensional, and variable experience for everyone regardless of age or special needs.
- Self–report of pain is the single most reliable indicator of pain. If the person is not able to speak for themselves then a surrogate's (family and friends) information is to be used and / or the NOPPAIN tool used.
- A treatment plan is to be based on the older adult's goals and contribute to their acceptable quality of life including functional abilities and comfort level.

- Non-pharmacological approaches should be implemented first, and in conjunction with pharmacological management
- If an analgesic is required the least invasive/burdensome method of drug administration is recommended beginning with a low dose and carefully titrating upward until optimal pain relief is achieved with the fewest adverse effects.
- Pain levels and pain related behaviours should be routinely monitored, assessed, reassessed, and clearly documented to facilitate treatment and communication between health care clinicians (Herr, K., 2006)

Background Information

Most health conditions associated with aging carry a substantial burden of pain. (Hadjistavropoulos, 2007). “Pain is not a normal part of the ageing process but the prevalence of persistent pain increases with age and illness, reaching its highest levels among older people residing in long-term care settings “(Australian Pain Society, 2005). “It should never be assumed that presenting problems are the result of ageing rather than the result of an underlying disorder that may be treatable” (Klinger, L & Spaulding, S.J.; 2001). Repeated studies have shown that approximately half of cognitively intact residents in care homes receive regularly scheduled pain medications while fewer than 25% of those with cognitive impairments had such orders (Martin, 2005). This is a concern considering the overall prevalence of pain in this population is 80% who suffer from pain to the point it effects their quality of life. (Hadjistavropoulos, 2010). The American Geriatric Society (AGS) has stated that ”clinicians have an obligation to prevent needless suffering and to do their best to provide effective pain relief, especially for those near the end of life.“ (p.1333). Martin (2005), stated that there continues to be concerns that pain in the frail elderly is often not identified, is under assessed, and misdiagnosed, especially among seniors with dementia. It is hoped that this Clinical Practice Guideline (CPG) will provide direction and supply the tools necessary for staff to conduct a thorough pain assessment and implement resident centered interventions to promote comfort and quality of life.

See Definitions (Appendix A)

Equipment and Supplies

- Pain Assessment and Monitoring tools for cognitively intact and those unable to verbally respond
- Non-pharmacological interventions e.g. comfort carts (see Section C.1.)
- Quiet, restful place to promote relaxation

Practice Guideline

Purpose:

To promote and integrate best practices for pain assessment and interventions into practice to improve each resident’s quality of life.

A. Assessment: (refer to Decision Tree: Appendix C)

Pain/Discomfort Identification and Assessment:

1. Assess all residents for pain/discomfort on admission or when there is a change in condition or behaviour (Appendix D and E)
2. Complete pain assessment when pain/discomfort is identified. Below is the ***Hierarchy of Pain Assessment Techniques*** *(Australian Pain Society, 2007)* which will assist to identify pain in those who are competent and those who are unable to verbally express their needs with recognition that all methods assist with understanding the resident’s comfort level.
   - Self-report
   - Supports (friends and family) reporting of resident’s pain/discomfort behaviour and/or activity changes
   - Search for potential causes
   - Observe resident behaviours particularly when providing care during transfers and activities

3. Identify the categories of pain, or pains: acute, persistent, malignant (Appendix A)
4. Identify the type of pain(s) (nociceptive, neurologic, or mixed), start date, frequency, intensity, common treatments to promote comfort (refer to Appendix A)
5. When pain is identified immediately complete an assessment / Observation tool to inform the team, the physician/NP/Pharmacist:
   - Verbal: The Residential Pain Tool for the Verbally Responsive (Appendix D) *(To be used by professional members of the Interdisciplinary Team)*
   - Non-Verbal: The NOPPAIN Tool (Appendix E) *(This tool is to be used by HCW/RCA's and other members of the Interdisciplinary Team)*
6. The chosen tool is to be used consistently for that person to monitor the pain intensity and response to treatment
7. Assessment to review history and to identify pattern of the pain:

1	General Medical History *Adapted from Providence Health Care (2007)*	Examples include: • Muscular skeletal conditions: arthritis, osteoarthritis, osteoporosis especially with vertebral fractures, old fractures, contractures, low back pain/spinal stenosis, foot pain, injuries due to a recent fall, muscle spasms, gout. • Diseases: Diabetes, peripheral vascular disease/amputations, CVA's, traumatic brain injury, complex regional pain syndrome or neurodegenerative diseases such as MS, ALS or Parkinson's disease. • Headaches, oral lesion (gingivitis, caries) cancers, skin conditions and/or wounds; constipation, infections such as UTI.
2	Physical examination	• Complete head to toe assessment and identify contributing factors. Gently touch body parts to observe any flinching, groans or other indications of pain. • Observe for protective posture while person is moving • Observe functional range of motion, strength, activity tolerance and endurance when resident is completing functional activities
3	Cognitive Status	• Mental status history (refer to Cognitive Performance Scale, CPS) • Assess person's ability to express pain/discomfort • Assess person's ability to indicate intensity of pain/discomfort • observe for signs of delirium: e.g. sudden change in cognitive functioning as pain may contribute to this condition
4	Review of treatments and medications	• Non-Pharmacological treatment options used – warm blankets, ice packs, lotions, massage, creams, aromatherapy, music therapy • Review medication history e.g. allergies, sensitivities • Review effects of medications used to treat medical conditions • Review use of medications taken to relieve pain and effect • Review use of modalities prescribed by physiotherapist such as electrical stimulation, ultrasound therapy, acupuncture.
5	Identify history, intensity and pattern of current pain	**O** - Onset: When did it begin? How long does the symptom last? How often does it occur? **P** - Pattern/Provoking/Palliate: What brings it on? What

	Adapted from Fraser Health. (2006). Guidelines for Use; Hospice Palliative Care – Symptom Assessment Acronym	makes it better? What makes it worse? **Q** - Quality: What does it feel like? How does the resident describe it? **R** - Region / Radiating: Where is it? Does it spread anywhere? **S** - Severity: What is the intensity of the pain on a scale of 0-5 or a scale of 0 -10 with 0 being none and 5/ 10 being the worst possible. Rate it now, at its best, at its worst, on average? How bothersome are the symptoms? Are there other symptoms as well? **T** - Treatment: What medications and treatments are currently being used? How effective are these? Are there any side effects from the medications and treatments? What has been used in the past? **U** - Understanding/Concerns: What does the resident believe is causing this symptom? How is this pain affecting their family? **V** - Values: What is the resident's goal? What is the resident's comfort goal or acceptable comfort level?
6	Nonspecific signs and symptoms that suggest the presence of pain *(VIHA Guidelines to Treatment of Chronic Pain in Long Term Care; Dec 2010)*	• Frowning, grimacing, fearful facial expressions, grinding teeth • Bracing, guarding, rubbing • Fidgeting, increasing or recurring restlessness • Striking out, increasing or recurring agitation • Eating or sleeping poorly • Sighing, groaning, crying, breathing heavily • Decreasing activity levels • Resisting certain movements during care • Change in gait or balance • Loss of motor function
7	Impact of pain/discomfort	• Describe activities and ADL's affected by the pain; such as decrease in socialization related to the discomfort • Assess if sleep is disrupted • Assess the effect of the pain/discomfort on the resident's appetite?
8	Psychosocial and cultural factors related to the pain	• What is the person's perceptions and belief of the meaning of pain o Belief system e.g. formal religion, spirituality, western vs traditional medicines • State if this person is stoic or demonstrative? • Describe how the person copes with pain/discomfort. Give an example • Measures which promote comfort e.g. warmth, soup • Review history of mental health and/or previous addiction before and during pain experience

B. Analysis:

- Determine the category of pain (acute, persistent, malignant) and identify the cause of the pain if known
- Determine the type of pain (nociceptive, neuropathic), location, intensity and frequency
- Determine which pain tool is best for this person to express intensity of pain

C. Intervention: (refer to Decision Tree: Appendix C)

- Complete the appropriate Pain Assessment Tool: Residential Assessment Tool for residents able to talk about their pain (Appendix D) or the NOPPAIN Tool for residents who are unable to verbally respond (Appendix E).
- Treat the underlying cause of discomfort/pain if known
- Develop goals with the person and their supports/supports (family and friends) and explore options that they believe will alleviate the discomfort
- Initiate pain monitoring tool (See Appendix F)

1. Common measures to promote comfort & alleviate pain:

a. Develop a positioning schedule that allows for frequent changes of position from bed to chair and while in bed; consider tilt-in-space wheelchair to maintain participation in valued activities and promote socialization
b. Review need for therapeutic surface and or positioning aids to promote comfort in bed e.g. cushions
c. Complete an assessment for seating, including positioning and therapeutic surfaces to increase comfort and to maximize sitting tolerance in wheelchair
d. To decrease stress for the resident, consider using adaptive clothing to reduce the number of transfers during ADL's and toileting.
e. Individualize exercise program to improve joint range of motion, increase muscle strength and enhance posture and gait stability.
f. Promote restful, quiet time when needed either in own room or a quiet area on the unit.
g. Identify strategies to promote participation in activities despite the presence of pain such as:
   - Develop a daily routine
   - Graded activity (completing part of task within tolerance)
   - Review pacing and timing of activities; promote rest breaks
h. Prescribe assistive devices to maintain participation in functional activities, compensate for range of motion restrictions, promote safety and manage pain.
   - Mobility device such as cane, walker, wheelchair, back rest,
   - Transfer device such as grab bars,
   - Hygiene device such as raised toilet seat, long sponge,
   - Device for gripping/reaching such as long shoe horn, long reacher
i. Review the need for interventions such: heat, ice, electrical stimulation
j. Gently remove wound dressings or use adhesive remover to alleviate pain
k. In conjunction with the resident, family, and friends the team will develop a plan that may include relaxation, distraction and socialization enjoyed by the person and perceived to alleviate pain, such as:
   - Conversations and socialization
   - Reminiscing and life review
   - Validation Therapy
   - Humor
   - Spiritual leader visits
   - Leisure activities; art , music
   - Aromatherapies, Therapeutic Touch
   - Spa-like activities e.g. manicure, massage
   - Provide warm articles e.g. sweater or warm blanket to promote comfort
   - Technology e.g. computers

2. Pharmacological Interventions: (refer to Residential Pain: Analgesic Steps – Appendix B)

a. Review previous use of analgesics and effect
b. Review PRN analgesic medications and doses
c. The preferred method of administration is regular dosing around the clock (ATC) with an analgesic for breakthrough/prn (refer to Appendix G)

d. Medications should be tailored to the type of pain and its severity
e. Consideration of age-related changes in drug sensitivity, efficacy, metabolism, and side effects is essential
f. Symptoms other than pain, such as constipation, insomnia, and depression, must be treated as part of a resident's pain management
g. **Start low and go slow**. Provide doses followed by careful upward titration, with frequent reassessment for dosage adjustments and optimal pain relief with prevention of adverse effects. Reassessments need to be stated and documented
h. Use the least invasive/burdensome form of drug administration
i. Scheduled administration before anticipated pain episodes is recommended
j. Consider adjuvants where no one medication has produced pain relief
k. Neuropathic pain should be evaluated and consideration given to the use of antidepressant and anti-epileptic adjuvant drugs - seek consultation re: appropriate medications
   - Tertiary tricyclic antidepressants should be used with caution due to higher rates of adverse effects
   - Other drug groups for pain, used appropriately may include corticosteroids, muscle relaxants, calcitonin
l. First drug of choice is Acetaminophen for mild to moderate osteoarthritis and low back pain
m. The recommended dose of Acetaminophen is from 2.6 to 4 grams in 24 hours, for chronic use in those with normal liver function. Dosage should be adjusted for decreased renal and/or liver function.
n. Opioids can be used for moderate to severe pain. Opioids such as codeine (in Tylenol #3) and morphine are not well tolerated in the older adult and it is recommended they not be used. If they are used for a specific reason they require frequent monitoring.
o. Introduce Opioids with clearly defined therapeutic goals and titrated to an effective dose without intolerable adverse effects, that follows the Analgesic Steps adapted for Residential Care. (Appendix B)
p. Those using opioids should be on a bowel routine
q. "Older aged persons are less likely to be at risk for opioid misuse or abuse" (American Geriatric Pain Society [AGPS]), 2009.
r. When long-acting opioid medications are used, breakthrough pain should be anticipated, assessed, and treated using short-acting immediate–release opioid medications, calculated at 10% of total daily dose. Consult with the pharmacist, physician, or NP
s. Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) are only recommended for short term use, for example one week or less, for flare-up of inflammatory diseases and then with extreme caution. Residents should be screened for any contraindications.
   - An adverse outcome may be gastrointestinal toxicity. Thus, a Proton Pump Inhibitor (PPI) should be considered whenever an NSAID is given to protect against gastric erosion. Consult with the pharmacist, physician, or NP
t. Only clinicians well versed in the use of and risks of methadone use should initiate it and titrate it to a satisfactory level. (VCH policy)

D. Monitoring:

- Refer to Pain Monitoring Record (Appendix F)
- Ongoing reassessment is needed as pain is usually not constant and fluctuates in quality and intensity. Start low and go slow but continue to reassess by trialing doses (titrating upwards) and by using a combination of drugs until an acceptable comfort level is achieved
- Signs of Opioid toxicity should be noted. These include but are not limited to;
  - Respiratory depression or respirations below 7 per minute
  - Pin-point pupils
  - Over-sedation
  - Confusion/hallucinations
  - Myoclonus – jerking, trembling, twitching

- Infections e.g. UTI or dehydration can produce signs similar to toxicity (pseudo-toxicity)
- See Opioid Management Tool, Providence Health Care (see Appendix G)

Expected Client/Family Outcomes

- The resident will verbalize or demonstrate an acceptable comfort level that enables them to have a sense of well being, contentment and the ability to participate in activities that contributes to their quality of life
- The families, friends, and support persons indicate that the person appears at ease and comfortable
- The pain assessment and monitoring tools demonstrate consistency in the acceptable limits of pain intensity

Patient/Client/Resident Education

- Pamphlet: Pain in the Older Adult (Cat # FM.800.P35)
  (order copies through VCH Patient Health Education Material Resource Catalogue)

Evaluation

- RAI assessments that trigger the Pain CAPS
- Chart Audit for Pain in the Elderly: Residential Care CPG (Appendix H)

Site Specific Practices

This is designed to include evidence-based best practices and to guide identification, assessment, and interventions to promote comfort level for pain.

Documentation (refer to Decision Tree Appendix C)

Observation Record

- Results of pain assessment screening on Admission

Pain Assessment Tool

- Completed thoroughly and appropriately:
- Tool for those cognitively intact (MMSE above 18)
- Tool to be used for those unable to verbally express themselves

Pain Monitoring Record

- To be initiated when there is a change in condition

Progress Record:

- Summary of the pain assessment indicating origin of pain if known, intensity, location, what the resident believes alleviates the pain.
- The pain tool chosen to be most effective for the resident

Care Plan:

- Each pain or discomfort site is to be stated as a focus of care and prioritized
- Goals of care are to be identified for each pain site as well as overall comfort level
- Each pain, discomfort focus is to state specific interventions to promote comfort, listing non-pharmacological as well as pharmacological interventions, time medication is to be administered and any special considerations
- Evaluation date is to be documented e.g. weekly

ADL Sheet

- Comfort measures for pain management

Related Documents

- VCH Delirium: Assessment & Care for Older Adults
- VCH Identification of Agitated and Excessive Behaviours and Client-Centered Interventions
- VCH Continence: Promotion and Maintenance
- VCH Bowel Function: Promotion and Maintenance
- VCH Falls Prevention
- PHC Pain (Persistent) in Frail Elders
- Vancouver Coastal Health Community Palliative Care Clinical Practice Guidelines.

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Developed by

CPD Developer Lead(s):

- Clinical Practice Leader, Residential Practice team, Vancouver - Community
- CNS, Seniors Program, Coastal HSDA
- CNS, Residential Palliative Care

Other members:

- Regional Leader Palliative Care, Vancouver
- Pharmacist, Vancouver
- Clinical Nurse Educator, Coastal
- Clinical Nurse Educator, Richmond
- OT, Vancouver Community
- Dietitian, VA
- PT, Residential Practice Team, Vancouver Community
- Palliative Medical Advisor, PHC
- Educator, Residential Practice Team, Vancouver Coastal Health
- Palliative Outreach Team, PHC
- Residential Quality Council, April 19, 2011
- Residential Care Complex Working Group, May 3, 2011

Endorsed by

Regional SharePoint 2nd Reading - Endorsement by:

- Health Authority Profession Specific Advisory Council Chairs (HAPSAC)
- Health Authority & Area Specific Interprofessional Advisory Council Chairs (HAIAC)
- Operations Directors
- VCH Professional Practice Directors

Final Sign-off & Approved for Posting by

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- Chief Nursing Officer & Executive Lead Professional Practice - VCH

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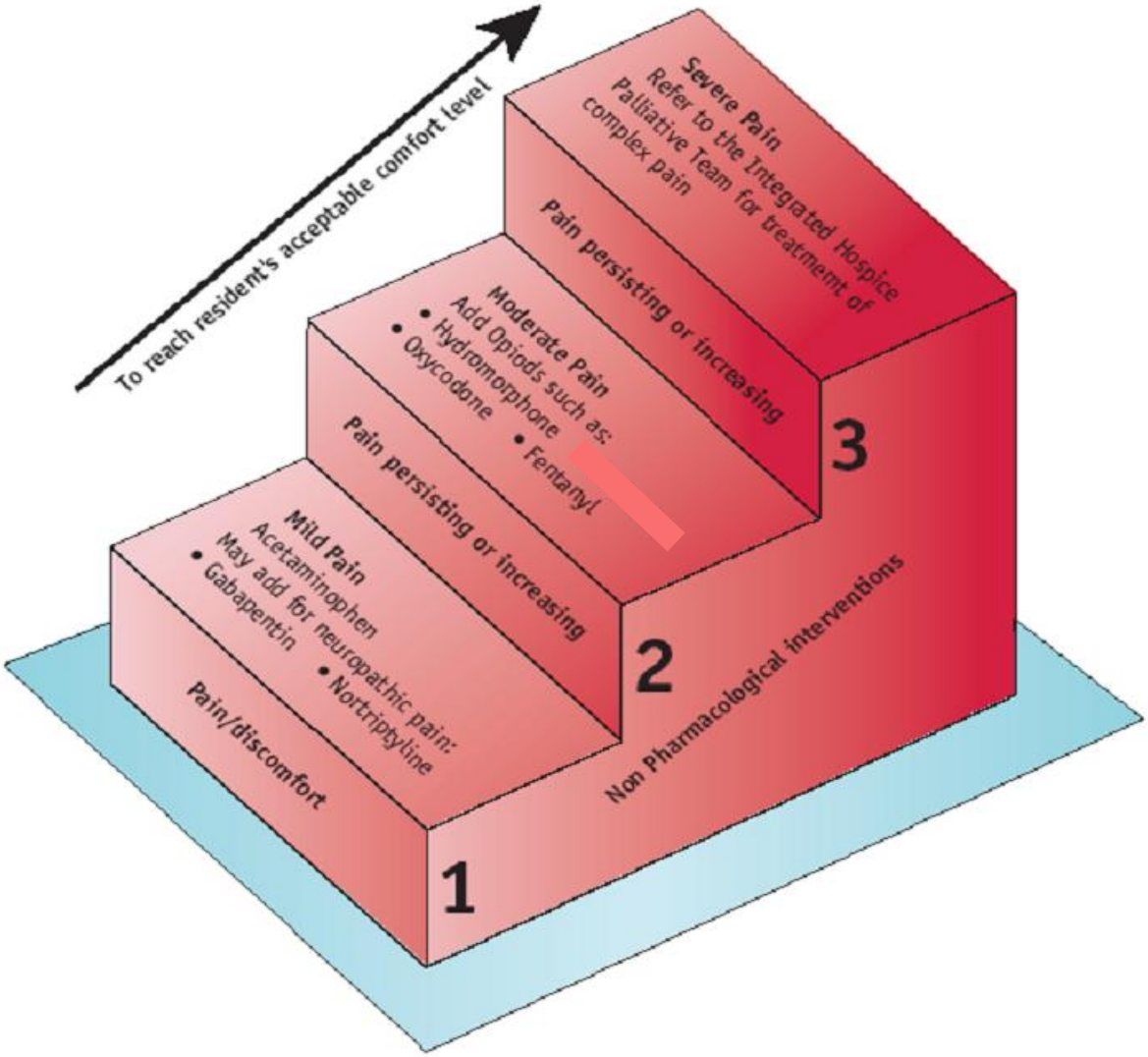
Appendix A - Definitions

Acute:	An indicator of a physiological problem that requires treatment, has a distinct onset and is accompanied by an increase in autonomic nervous system signs which may subside when the disease/injury is resolved
Addiction:	A chronic, neurobiological disease characterized by one or more of the following behaviors: impaired control over drug use, compulsive use, continued use despite harm and craving (AGS, 2009. p. 1339)
Analgesic:	A drug that relieves pain. The opioid analgesic acts in the central nervous system and alters the patient's perception; they are more often used for severe pain. The non-narcotic analgesics act on the site of the pain, do not produce tolerance or dependence, and do not alter the patient's perception; they are used for mild to moderate pain. (Mosby's Medical & Nursing dictionary, 2nd Edition, 1986)
Adjuvant drugs:	A drug that has a primary indication other than pain (e.g., antidepressant or anticonvulsant) but is also analgesic for some painful condition (McCaffery & Pasero, 1999)
Malignant / Cancer Pain:	Associated with cancer, malignancy that can invade and destroy nearby tissue and that may spread to other parts of the body. (McCaffery & Pasero, 2010)
Pain:	A complex phenomenon caused by noxious sensory stimuli or neuropathic mechanisms. An individual's memories, expectations, and emotions modify the experience of pain. (Sternbach, 1978 and American Geriatric Society, 2009).
Persistent pain:	Pain that continues for a prolonged period of time and may or may not be associated with a well-defined disease process. (American Geriatric Society, 2009)
"Total pain":	Characterizes the multi-dimensional nature of the palliative patient's pain experience to include the physical, psychological, social, and spiritual domains. *Term coined by Dame Cicely Saunders* Anita Mehta, Anita and Chan, Lisa. (2008).
Tolerance:	Is a decrease in one or more effects of the opioid (e.g. decreased analgesia, sedation, or respiratory depression). (McCaffery & Pasero, 1999)
Neuropathic Pain:	Pain initiated or caused by a primary lesion or dysfunction in the peripheral or central nervous system (McCaffery & Pasero, 1999).
Nociceptive Pain:	Results from activation of nociceptors, specialized nerve endings that respond to high threshold noxious stimuli and generally serve a protective function. (Orzo, 2000). "
Somatic pain:	Localized pain that can come from bone, joint, muscle, skin, or connective tissue with an aching, throbbing, or pounding quality that usually responds to non-opioid analgesics. (McGarvey, Erin. (2008). Treatment of Acute Mild Pain. (2008). BC Nurses RNIA Decision Support Tool.
Visceral Pain:	Poorly localized or generalized pain from organs such as the gastrointestinal tract and pancreas that may have a cramping quality and respond to non-opioid analgesics but often requires opioids McGarvey, Erin. (2008). Treatment of Acute Mild Pain. (2008). BC Nurses RNIA Decision Support Tool.
Suffering:	The state of of anquish one bears, injury or loss, "life pain" that affects others around them. Person feels out of control and overwhelmed by pain. Source of pain is unknown (Roy 1995).

Appendix B – Analgesic Steps (Modified WHO Ladder)



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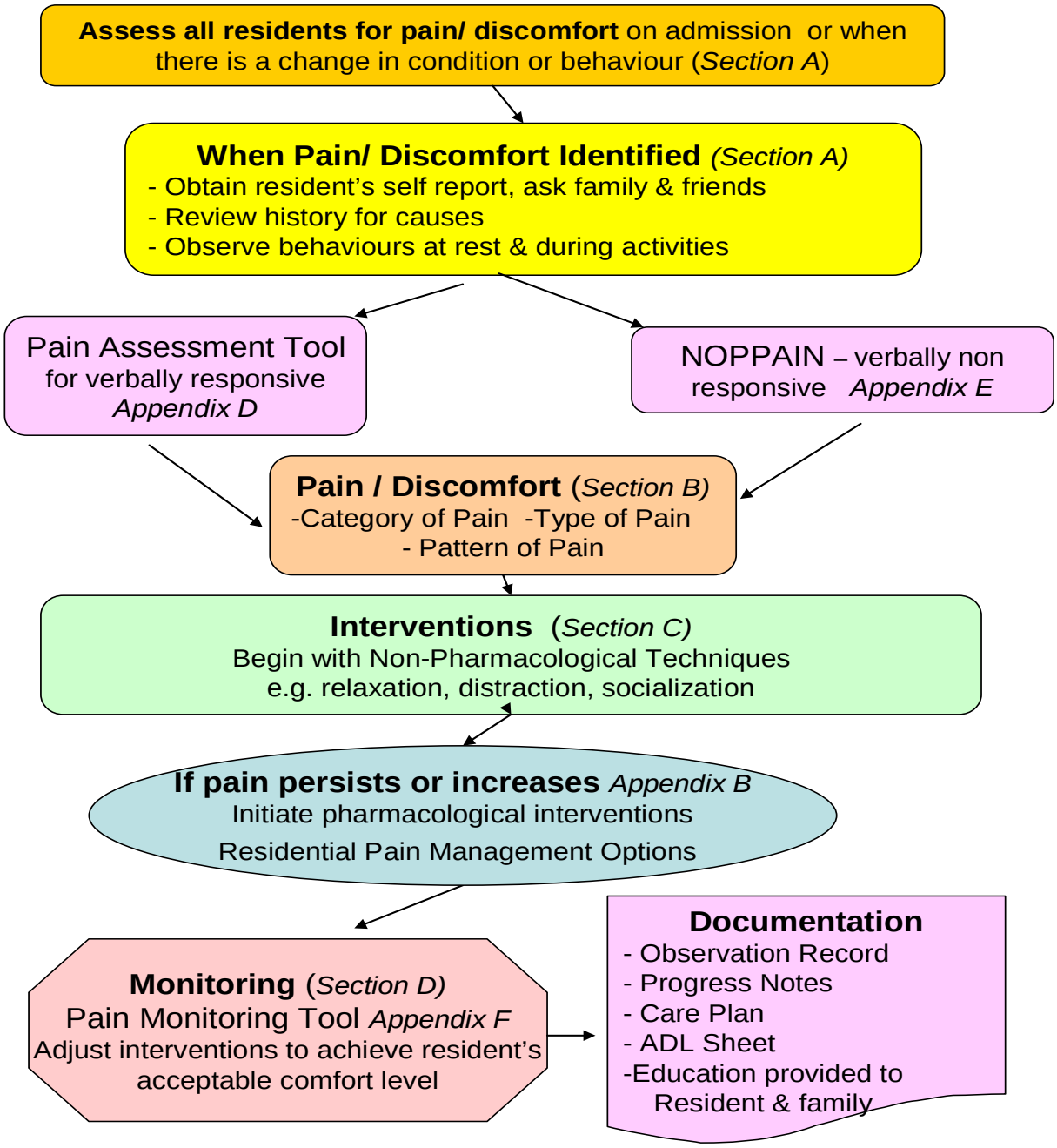
Appendix C – Decision Tree

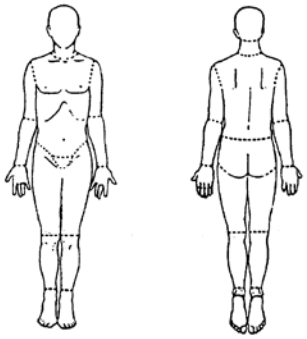


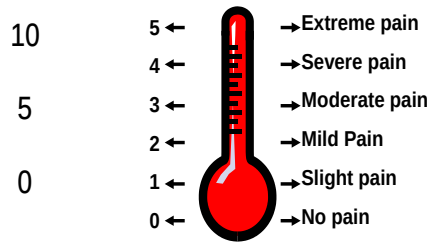
Appendix D – Pain Assessment Tool for the Verbally Responsive

NAME _____ ***DATE*** _____

1. Where is your worst pain? (point to the sp_____

2. Where else do you have pain or discomfort? _____





3. ***Onset –*** When did the pain start? _____

4. ***Pattern*** - What makes the pain(s) better? _____ worse? _____

5. ***Quality*** - How would you describe your pain(s)? – Throbbing ☐, shooting ☐, numbness ☐, stabbing ☐, sharp ☐, dull ☐, aching ☐, burning ☐, pins and needles ☐, grinding ☐.
6. ***Radiating*** - Does the pain(s) spread to other areas? _____

7. ***Severity*** - How would you rate your pain(s), 0-10, 0-5 scale ☐ Descriptions ☐ Faces ☐ _____

8. ***Timing*** - Is the pain(s): Constant? ☐ Come and go? ☐ Only with movement? ☐

9. ***Understanding*** - What do you think causes the pain(s)? _____

10. ***Value*** – What is your acceptable comfort level? _____

11. What medications do you use? _____
    Do they help? _____

12. What have you used in the past? _____
14. Does your pain(s) affect your: Sleep ☐ Appetite ☐ Activity ☐ Mood ☐ Other ☐
15. Do you have any concerns about taking pain medications? Yes ☐ No ☐
    If yes, describe: _____

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Appendix E – Observation for Non-verbal Responsive Residents (NOPPAIN)

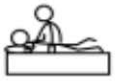
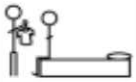
NOPPAIN

(Non-Communicative Patient's Pain Assessment In

Activity Chart Check List

Name of Evaluat
Name of Resident
Date:
Time:

DIRECTIONS: Nursing assistant should complete at least minutes of daily ca activities for the resident while observing for pain behaviors. This form should be completed immediately following care activities

		Did you do this? Check Yes or No	Did you see pain when you did this? Check Yes or No
(a) Put resident in bed OR saw resident lying down		☐ YES ☐ NO	☐ YES ☐ NO
(b) Turned resident in bed		☐ YES ☐ NO	☐ YES ☐ NO
(c) Transferred resident (bed to chair, chair to bed, standing or wheelchair to toilet		☐ YES ☐ NO	☐ YES ☐ NO
(d) Sat resident up (bed or chair) OR saw resident sitting		☐ YES ☐ NO	☐ YES ☐ NO
(e) Dressed resident		☐ YES ☐ NO	☐ YES ☐ NO

		Did you do this? Check Yes or No	Did you see pain when you did this? Check Yes or No
(f) Fed resident		☐ YES ☐ NO	☐ YES ☐ NO
(g) Helped resident stand OR saw resident stand		☐ YES ☐ NO	☐ YES ☐ NO
(h) Helped resident walk OR saw resident walk		☐ YES ☐ NO	☐ YES ☐ NO
(i) Bathed resident OR gave resident sponge bath		☐ YES ☐ NO	☐ YES ☐ NO

REMEMBER: Make sure to **ASK THE PATIENT** if he/she is in pain!

Pain Response/Responsibility (What did you see and hear?)

Pain Words?
•"That hurts!" •"Ouch!"
•Cursing •"Stop that!"

☐ YES ☐ NO
How intense were the pain words?
0 1 2 3 4 5
Lowest Possible Intensity — Highest Possible Intensity

Pain Faces?
•grimaces •winces
•furrowed brow

☐ YES ☐ NO
How intense were the pain faces?
0 1 2 3 4 5
Lowest Possible Intensity — Highest Possible Intensity

Bracing?
•rigidity •holding •guarding (especially during movement)

☐ YES ☐ NO
How intense was the bracing?
0 1 2 3 4 5
Lowest Possible Intensity — Highest Possible Intensity

Pain Noises?
•moans •groans •grunts
•cries •gasps •sighs

☐ YES ☐ NO
How intense were the pain noises?
0 1 2 3 4 5
Lowest Possible Intensity — Highest Possible Intensity

Rubbing?
•massaging affected area

☐ YES ☐ NO
How intense was the rubbing?
0 1 2 3 4 5
Lowest Possible Intensity — Highest Possible Intensity

Restlessness?
•frequent shifting •rocking
•inability to stay still

☐ YES ☐ NO
How intense was the restlessness?
0 1 2 3 4 5
Lowest Possible Intensity — Highest Possible Intensity

Locate Problem Areas

Please "X" the site of any pain
Please "O" the site of any skin problems

FRONT BACK

Snow AL, O'Malley K, Kunik M, Cody M, Bruera E, Beck C, Ashton C. Developed with support from the U.S. Veterans Affairs Health Services Research & Development Service and the National Institute of Mental Health. For more information, contact Dr. Snow at asnow@bcm.tmc.edu. *(This document may be reproduced*

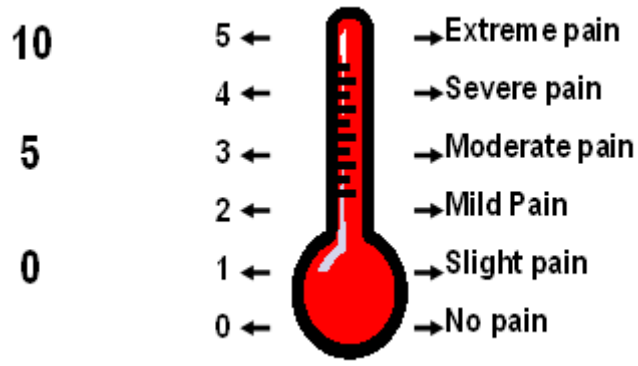
NOPPAIN (2nd Page)

Non - Communicative Patient's Pain Observation Instrument Activity Chart Check List

Name of Evaluator _____
Name of Resident _____
Date: _____
Time: _____

Rate the Resident's pain at the highest level you observed during care. (circle your answer)

Pain Thermometer Scale



From: Snow, A.L.; O'Malley, K; Kunik, M; Cody, M.; Bruera, E.; Beck, C.; Ashton, C. (2004). A Nursing Assistant-Administered Pain Assessment Instrument for Use in Dementia. Dement Geriatr Cogn Disor. 17:240-246.

Appendix F – Pain Monitoring Record

Vancouver CoastalHealth

RESIDENTIAL CARE

PAIN MONITORING RECORD

Site: _____

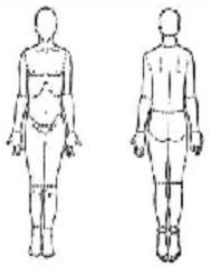
LOCATION
(List most severe first)

0 1 2 3 4 5 6 7 8 9
0 1 2 3 4
No pain Moderate Extreme

1. _____
2. _____
3. _____
4. _____
5. _____

NONVERBAL INDICATORS INCLUDE:

Verbally Excessive	V	Rubs or protects part	P
Moans/sighs	M	Restless/rocks	R
Weeps/cries	W	Holds body part	H
Cries when moved	C	Fidgets	F
Grimaces/grunts	G	Resistive to touch	T

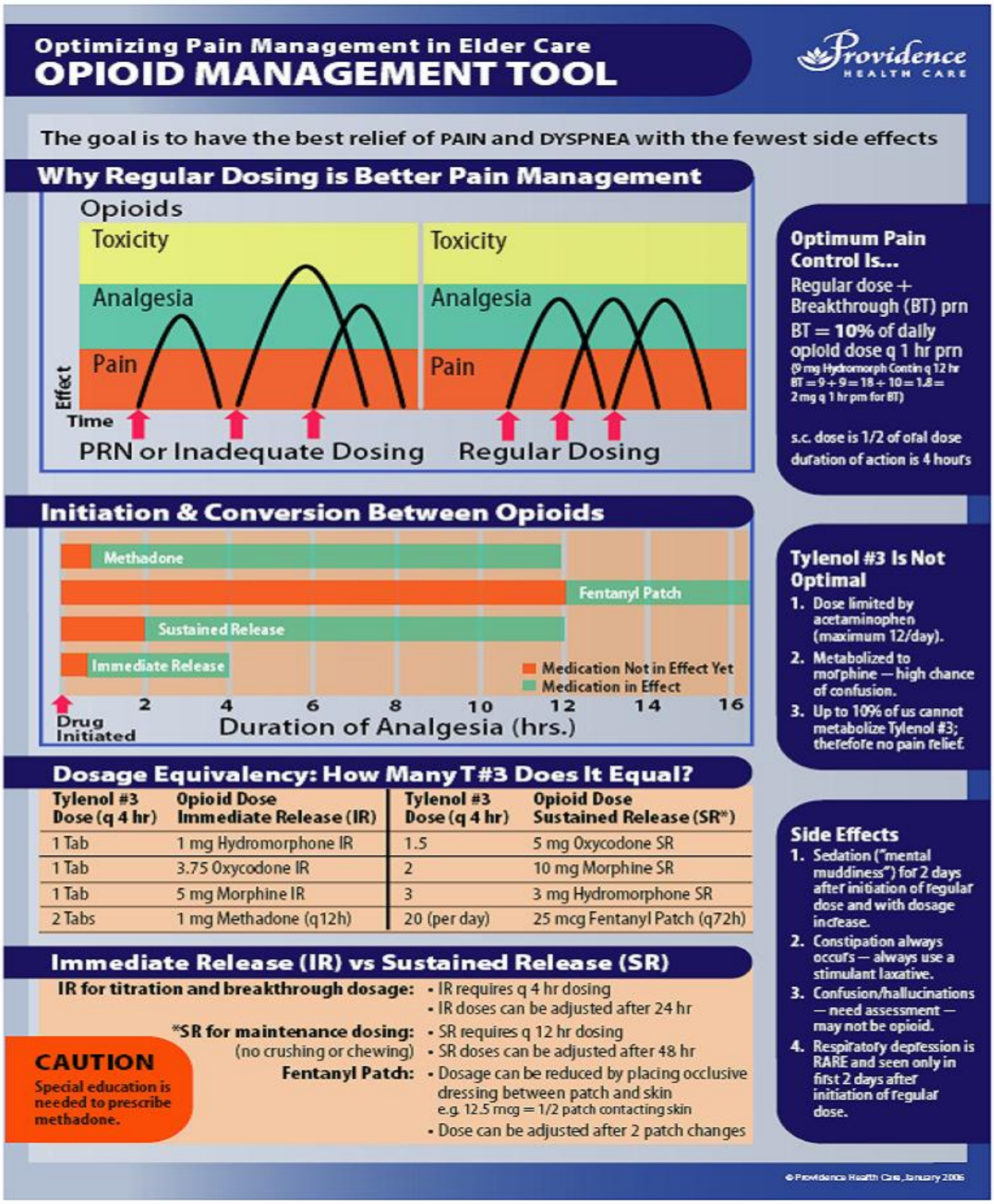


PAIN INTERVENTIONS & EVALUATION

Date:														
Time:														
Location:														
Pain Intensity (0-10/0-5):														
Observed indicator of Pain (pain behaviors):														
Intervention e.g. heat, reposition, distraction, medication														
EVALUATION ONE HOUR LATER														
Pain Intensity (0-10/0-5):														
Observed Indicator of Pain (pain behaviors 1hr later):														
Initials:														

VCH.0118 | FEB.2011

Appendix G – Opioid Management Tool (Providence Health Care)



Appendix H – Audit Tool

Reporting Period:	**Signature of Evaluator:**
To use this audit/review tool: Choose chart information that is documented or placed in the chart only. **Key: Met=M; Not Met=N; Not Applicable=N/A; C= % Compliance**	

STANDARD/CRITERIA	**RESIDENT'S ROOM #/ID**								**# M**	**# N**	**# N/A**	**% C**
Pain assessment												
Completed on admission												
Completed when there was a change in condition or behavior												
Pain Assessment Tool Used												
Stated which tool to use - Pain Assessment Tool for the verbally responsive -NOPPAIN tool												
Stated which intensity scale: 0 – 5 or 0 -10												
Chosen Pain Tool completed												
Pain Flow sheet												
Initiated when pain identified												
Pain interventions & evaluations completed												
One hour re-evaluation completed on sheet												
Progress Record												
Summary of pain assessment including origin if known, identified pattern and what improves the discomfort												
State tool and Intensity scale used												
States which non-pharmacological interventions were tried and the outcomes												
Summarizes response to medications												
Noted if physician notified if pain persisted												
Care Plan												
States the residents goals												
Identifies each site of pain and interventions												
Identifies evaluation date for each pain site												
Physician's Order/MAR												
Medication, dosage (regular & PRN)												
Alternate dosage or medication for breakthrough												
Total # M:												
Total # M+N:												
% Compliance = $\frac{M}{M+N}$ X100:												