AMDA Clinical Practice Guideline: Pain Management in ALFs

This document focuses on the management of pain in ALFs. It is based on the American Medical Directors Association's (AMDA) clinical practice guideline, Pain Management in the Long Term Care Setting. It recommends processes that, if followed, will help to ensure that pain among ALF residents is adequately recognized, assessed, treated, and monitored. In general, guidance is directed to the entire interdisciplinary care team. Facility size, available resources, existing policies and procedures, and other factors may influence the precise manner in which a particular ALF implements and uses these processes.

Definition

Pain is defined as an individual's unpleasant sensory or emotional experience. Acute pain involves abrupt onset or escalation. Chronic pain is persistent or recurrent. Pain is a highly subjective, personal experience for which there are no consistent objective biological markers.

Despite the best efforts of practitioners and staff, pain is common in the assisted living setting. However, although disorders that can cause chronic pain are more common with increasing age, pain itself is not a normal part of aging.

Approximately 45-80% of long term care (LTC) residents are estimated to have chronic pain. The precise figures are unknown, as pain in the long term care setting is sometimes under-recognized and under-treated; and treatment for chronic non-cancer pain, especially among those with non-terminal illness, is inconsistent.

Nonetheless, pain in elderly patients often can be reliably detected and effectively treated. Although the recognition and treatment of pain in ALFs present special challenges, a systematic effort can result in positive outcomes.

Management of Acute Versus Chronic Pain

Although the principles of pain management are similar for both

acute and chronic pain, some important distinctions exist in their recognition, assessment, treatment, and monitoring. For example, the causes and characteristics of chronic pain are more likely to have been identified previously. When a resident is in acute pain, however, both causes and characteristics of the pain should be identified as rapidly as possible.

Whereas the necessary duration of interventions for the individual with acute pain generally will last only until the pain resolves, individuals with chronic pain commonly need long-term interventions. At the same time, many individuals with chronic pain also have sudden and extreme exacerbations requiring a similar approach to that used for the treatment of acute pain.

Table 1.
Common Misconceptions about Pain in Elderly People

- To acknowledge pain is a sign of personal weakness. (Conversely, to bear pain without complaint denotes strength of character.)
- Chronic pain is an inevitable part of aging and nothing can be done about it.
- Pain is a punishment for past actions.
- Chronic pain means death is near.
- Chronic pain always indicates the presence of a serious disease.
- Acknowledging pain will mean undergoing intrusive and possibly painful tests.
- Acknowledging pain will lead to a loss of independence.
- The elderly, especially the cognitively impaired, have a higher tolerance for pain.
- The elderly and the cognitively impaired cannot be accurately assessed for pain.
- Patients in long term care say they are in pain to get attention.
- Elderly patients are likely to become addicted to pain medications.

Barriers to Recognizing Pain in ALFs

Pain is under-recognized for many of the same reasons that the early signs and symptoms of many other conditions—such as depression, congestive heart failure, and adverse effects of medications—go undetected in ALF residents. These include:

- Different response
- Cognitive and communication barriers
- Cultural and social barriers
- Co-existing illnesses and multiple medication use
- Staff training and access to appropriate tools
- Practitioner limitations
- System barriers
- Poorly functioning care processes and teams
- Inadequate communication among interdisciplinary team members
- Insufficient commitment to pain management

In addition, several very specific reasons for the under-recognition of pain are rooted in the nature of pain and societal attitudes toward it. Pain is subjective and lacks consistent objective biological markers. Numerous myths persist about pain in the elderly; and caregivers, residents, and families may hold misconceptions that prevent them from providing or seeking adequate pain treatment (see Table 1). For example, residents may equate pain with serious illness and be afraid to report it or they may see pain as a sign of weakness. At the same time, caregivers, family members, and even some practitioners may hesitate to administer opioids for fear of getting the resident addicted. It is the job of the facility staff and of the practitioner to relieve those fears and to dispel the myths that may exist about opioid use.

Up to 45–80% of long term care residents are estimated to have chronic pain.

The most accurate and reliable evidence of the presence and intensity of pain is the resident's self-report. However, older people often describe discomfort, hurting, aching, or soreness, rather than using the specific word "pain." Therefore, ask the resident using a variety of such words, (eg, "Are you uncomfortable?" or "Do you ache?") when asking about pain.

Chronic pain is usually not constant; it fluctuates over time in both character and intensity. Although staff and practitioner assessments should incorporate a resident's self-report of pain, additional direct examination is important in helping to identify pain characteristics and possible causes. Therefore, while a patient's self-report of pain should never be ignored, this should only be one component of the diagnosis.

It is important to note that a specific cause of pain often cannot be identified, even after diagnostic testing has been performed. In some cases, diagnostic testing to determine the causes of pain may be precluded (eg, when a resident—or a resident's decision-maker—has requested that no diagnostic tests be performed). However, pain should always be addressed, even if its cause is unknown.

Description of Pain in ALFs

Most chronic pain in ALFs is related to arthritis and musculoskeletal problems. Surveys have found that nearly one in four residents in the long term care setting has some form of arthritis. Pain caused by nervous system damage or disease, including diabetic neuropathy and postherpetic neuralgia, also is common as is pain associated with osteoporosis.

Pain can cause or lead to other conditions that can adversely affect residents' independence, level of functioning, and quality of life. These include deconditioning, gait disturbances, falls, slow rehabilitation, multiple medication use, cognitive impairment, malnutrition, depression, sleep disturbance, impaired mobility, and decreased socialization. At the same time, chronic pain in elderly people also contributes to increased health care utilization costs.

Table 2.
Complementary Therapies for Pain Management

ALF should consider offering complementary therapies for pain management, including:

- Physicial Therapies
  - Exercise
  - Physical and occupational therapy
  - Positioning (eg, braces, splints, wedges)
  - Cutaneous stimulation (eg, superficial heat or cold, massage therapy, pressure, vibration)
  - Neurostimulation (eg, acupuncture, transcutaneous electrical nerve stimulation)
  - Chiropractic treatments
  - Magnet therapy
- Nonphysical Therapies
  - Cognitive/behavioral therapy
  - Psychological counseling
  - Spiritual counseling
  - Peer support groups
  - Alternative medicine (eg, herbal therapy, naturopathic and homeopathic remedies)
  - Aromatherapy
  - Music, art, drama therapy
  - Biofeedback
  - Meditation, other relaxation techniques
  - Hypnosis

Pain in Cognitively Impaired Residents

Pain frequently is undertreated in cognitively impaired residents, partly because they are less able to express their pain in words (eg, "My hands hurt."). However, contrary to a commonly held belief, these residents often are capable of communicating about their pain in other ways. For example, one study tested the ability of cognitively impaired residents in a long term care facility to complete scales that used words or pictures to describe the severity of pain.[1] The authors found that more than 80% of the residents could complete at least one of five scales.

Caregivers, family members, and others should be encouraged to look for signs that cognitively impaired residents could be experiencing pain. These include facial expressions (grimacing, frowning), moaning, rubbing hands or other body parts, crying, and/or not eating. It is important for all front-line staff members to be educated about these nondescript signs and symptoms of pain so that they are better able to identify when a resident may be in pain. At the same time, even when they can't say directly that they are in pain, their words may suggest discomfort nonetheless. Expressed memories about a time when they were hurt may relate to current pain they are feeling. For example, a resident might talk about a time when he fell out of a tree and broke his leg.

Managing Pain

It is suggested that clinicians take a "start low, go slow" approach to treating pain in ALF residents, with a focus on taking the least invasive route and reassessing frequently. Both nonpharmacologic and pharmacologic treatments have value in treating pain.

Nonpharmacological treatments include cognitive therapies, biofeedback, and behavior therapy, as well as topical analgesics such as counterirritants and capsaicin cream. A number of complementary therapies also may be helpful (see Table 2).

A medication schedule is advised for pharmacologic treatments. Several non-steroidal anti-inflammatory drugs (NSAIDs) are considered inappropriate for elderly individuals. These include indomethacin, meclofenamate, piroxicam, and tolmetin. Also considered inappropriate for this population are the opioids meperidine, propoxyphene, pentazocine, and nalbuphine, as well as phenylbutazone, trimethyl benzamide, flurazepam, amitriptyline, long-acting benzodiazepines, muscle relaxants, and anticholinergics.

For mild to moderate pain, consider a trial with acetaminophen. However, it is important to note that caution is necessary in administering acetaminophen to patients who also are taking warfarin or who have liver disease or alcohol abuse problems. Studies have shown that patients often say they get greater relief from NSAIDs over acetaminophens; and a combination of acetaminophen and tramadol provides greater pain relief than either alone and results in quicker pain relief than tramadol by itself. This combination also has the benefit of reduced adverse drug reactions.

Oral immediate-release opioid dosing calls for a dose every four

hours, adjusted daily. Dosage can be adjusted 25% to 50% for mild or moderate pain and 50% to 100% for severe or uncontrolled pain. This adjustment can be made more quickly for severe, uncontrolled pain. For extended-release oral opioid dosing, dosage is product-specific, but typically administered every 8, 12, or 24 hours. It is important that residents and caregivers know that these tablets should not be crushed or chewed.

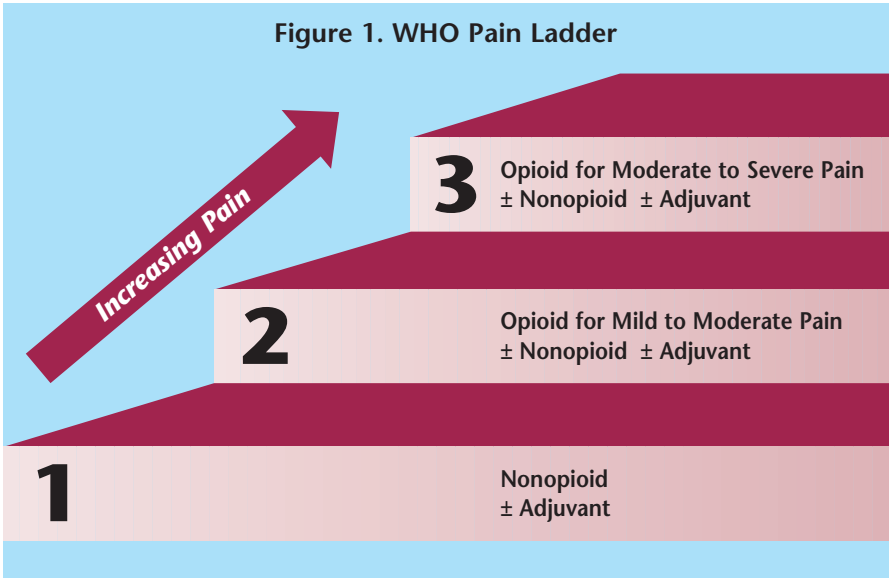
Common adverse effects of opioids may include constipation, dry mouth, nausea or vomiting, sedation, and sweating. It is important to prescribe anticonstipation medications, such as stool softeners, when prescribing opioids. Nurses accepting or receiving orders for opioids should ask the practitioner for anticonstipation medications if none have been ordered. The ALF also should have bowel regimen care plans in place for those residents who are on opioids.

The WHO Pain Ladder is useful in selecting drug therapies to treat pain (see Figure 1). It is essential to follow this ladder, even in cases where hospice is being instituted. It is inappropriate to go from an as-needed (PRN) non-opioid medication to an opioid pain patch. Even in cases where hospice care is warranted, an appropriate dose of morphine that controls the resident's pain must be established prior to going to an opioid patch.

Guiding Principles

In ALFs, the comfort and well-being of the individual resident should always be paramount. This principle is the foundation for effective pain management. Individualized care planning ensures that pain management is tailored to each resident's needs, circumstances, conditions, and risk factors. Members of the interdisciplinary care team have a responsibility to advocate for resident comfort and to find clinically appropriate, cost-effective ways of achieving it.

Figure 1. WHO Pain Ladder



Pain can cause or lead to other conditions that can adversely affect independence and quality of life.

Facility Preparedness

As previously noted, many factors make pain assessment and management in the assisted living setting challenging. A facility commitment to resident comfort is essential to overcoming these barriers. Managers should develop and implement policies and procedures or guidelines that facilitate the recognition, assessment, treatment, and monitoring of pain.

Communication

Appropriate staff should communicate information about a resident's pain routinely and in a timely fashion to those who will act on these reports. Facilities should consider encouraging all members of the interdisciplinary care team to use a common vocabulary to describe pain and a standard array of pain assessment tools. It is important to have ongoing and consistent staff training regarding the use of these tools to ensure that they are being used properly.

It is useful to have a systematic approach to care that includes seeking the input of individuals such as facility assistants and family members who are familiar with the resident and can describe his or her symptoms. Other ideas that can help ensure adequate pain recognition and management in ALFs include:

- Designating a staff member to ensure that all residents in the facility are properly assessed for pain and that all residents who have pain receive treatment
- Including documentation of ongoing pain assessment and treatment in every resident's medical record

Ensure that the facility's processes for assessing residents, reporting critical information, and obtaining timely and appropriate responses from physicians are functioning optimally and that any problems related to these processes are addressed.

Importance of Staff Education

Health care professionals at all

levels need ongoing education about pain management. Training and orientation programs for employees and affiliated professionals in ALFs should include education about all aspects of pain assessment and treatment. Nursing assistants and other direct caregiving staff should receive training and mentoring in pain recognition. When they help identify pain in a resident, they should receive proper recognition and praise.

A pain management education program is important and should:

- Address misconceptions and myths about pain that hinder its recognition and treatment
- Help staff to recognize and overcome misconceptions and biases that may affect their response to residents' complaints of pain or behaviors suggestive of pain
- Train direct caregiving staff in the proper use of pain assessment tools
- Educate staff and practitioners about the effective operation of the facility's overall care delivery process, which includes timely, appropriate pain assessment and management
- Educate staff, practitioners, residents, and families or advocates about the benefits of various treatments for pain and the risks and limitations of pain medications
- Educate staff and practitioners about the benefits of interventions that may indirectly influence pain (eg, the benefits of exercise in improving strength and mobility and of activities in helping address anxiety and depression that may lead to an exaggerated pain response)
- Promote an aggressive, coordinated approach to pain management throughout the facility

Staff Deployment

Some evidence suggests staffing policies that enable caregivers to remain with the same residents for extended time periods improve pain detection. In one study, nurses who had developed relationships with cognitively impaired residents could tell when one of them was in pain by observing subtle changes in the individual's behavior or demeanor.[2] These results suggest that consistent staffing that enables familiarity with a resident's baseline characteristics facilitates the recognition of important condition changes, including the onset of or an increase in pain. For various reasons, however, facilities may find it difficult to accomplish the desirable goal of consistent staffing. Nonetheless, this should be a goal whenever possible.

Most ALF residents have predisposing factors for the development of chronic, non-cancer pain. For this reason, a high index of suspicion for the presence of pain is warranted. Every resident should
be regularly and systematically assessed for pain. The assessment process should be conducted at least:

- On admission to the ALF facility
- At regularly scheduled reviews
- At any time that there is a change in condition
- At any time it is suspected that a resident is in pain

Conclusion

By implementing the steps described in this guideline, health care providers can meet the expectations of residents, their families, advocates, and policy makers for adequate, compassionate pain management. Simultaneously, to serve their residents most effectively and to help each resident achieve the highest practicable level of well being, ALFs should review and—as needed—revise its operating procedures to incorporate new information about pain recognition, assessment, treatment, and monitoring. Tools such as the complete clinical practice guideline on pain management developed by AMDA can make these processes more thorough and effectively. ALC

References

1. Parke B. Realizing the presence of pain in cognitively impaired older adults: gerontological nurses' ways of knowing. *J Gerontol Nurs* 1998;24:21-28.

2. Stein WM, Ferrell BA. Pain in the nursing home. *Clin Geriatr Med* 1996;12(3):601-613.

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