The PMG Kit for Aged Care

An implementation kit to accompany The Australian Pain Society's
Pain in Residential Aged Care Facilities: Management Strategies

Prepared by Edith Cowan University
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If you are unable to download the PDF file please send an email to: acc@health.gov.au for a copy to be sent to you.

Copies of the guidelines, Pain in Residential Aged Care Facilities – Management Strategies, is available as a download or as a hard copy from the Australian Pain Society website at www.apsoc.org.au

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Introduction

Pain in older people is a common problem, with studies estimating that between 26%[1] and 86%[2] of residents in residential aged care facilities experience pain on a regular basis. Pain can have a significant effect on an individual's quality of life, and may also decrease their ability to function effectively. Pain can limit mobility, decrease social interactions, decrease appetite, alter sleep and rest patterns and cause changes to psychological wellbeing. People who experience chronic pain can become anxious and depressed. However, in most instances pain is manageable with the use of pharmacological and non-pharmacological pain management strategies.

The Australian Pain Society has addressed the issue of pain in *Pain in Residential Aged Care Facilities: Management Strategies*[3], which presents suggestions that can assist in identifying and assessing residents' pain effectively, managing pain using a combination of pharmacological and non-pharmacological treatment options, and also examines issues of quality management and organisational structure related to pain management. The Pain Management Guidelines (PMG) Kit for Aged Care has been developed for use with the *Pain in Residential Aged Care Facilities: Management Strategies*[3] to assist Residential Aged Care Facilities to better manage residents' pain.

References:

1. McLean, W.J. & Higginbotham, N.H. (2002). Prevalence of pain among nursing home residents in rural New South Wales. *Medical Journal of Australia*, 177, 17-20.
2. Madjar, I. & Higgins, I.J. (1997). Unrecognised pain in nursing home residents. *Veterans Health*, 60, 13-15.
3. The Australian Pain Society. (2005). *Pain in Residential Care Facilities: Management Strategies*. North Sydney, NSW.

Using the PMG Guide

Using the PMG Kit for Aged Care

The PMG Kit for Aged Care is designed to be used in conjunction with the Australian Pain Society's *Pain in Residential Aged Care Facilities: Management Strategies*[1] to assist in implementing the pain management practices in your facility. In particular, this kit offers:

- A summary of the management strategies, presented as a series of pain management guidelines, each with a brief explanation
- A ready reference to link the guidelines to the relevant pages in the *Pain in Residential Aged Care Facilities: Management Strategies*[1] publication
- A pre-implementation checklist to alert you to specific issues that need to be considered prior to implementation
- A post-implementation checklist to help you to assess your progress
- Fact sheets to assist in providing information to key people, including residents and families, health professionals and care workers
- A template for an information sheet for visiting General Practitioners that can be adapted to suit specific facilities
- Samples of resident documentation to be used for educational purposes
- Posters of essential pain management information.

IMPORTANT:

The PMGs are a summary only and should not be used in isolation to guide practice. *Pain in Residential Aged Care Facilities: Management Strategies*[1] is an evidence based document that should be used to guide decision making about changes to current practice.

Pain Management Guidelines

Section 1: Pain Identification and Assessment

Guideline 1

Pain identification is an ongoing process that should occur:

- on admission
- in the event of a significant change in a resident's condition
- any time pain is suspected
- at least every three months.

Guideline 2

Pain identification requires a two-part approach, using staff observation techniques and residents' self reports of pain.

Guideline 3

Pain needs to be properly diagnosed so that appropriate and effective management strategies can be planned. Diagnosis will explore the specific type of pain being experienced.

Guideline 4

A thorough pain assessment explores multiple factors. These include:

- pain history
- general medical history
- physical examination
- physical impact of the pain
- social impact of the pain
- psychosocial factors related to the pain
- a review of medications and treatments
- severity and intensity of the pain
- prognosis.

Guideline 5

The use of an appropriate, structured pain assessment tool will facilitate thorough assessment of a resident's pain.

Guideline 6

A uni-dimensional pain assessment scale can be used frequently for ongoing evaluation of pain intensity and response to treatment.

Section 2: Treatment Strategies

Guideline 7

A combined treatment plan using pharmacological and non-pharmacological therapies is more likely to relieve pain than a single treatment option.

Guideline 8

Multidisciplinary collaboration enhances pain management. The multidisciplinary team may consist of the resident and their family, nurses, doctors, physiotherapists, occupational therapists, other allied health professionals and care workers.

Guideline 9

Pain management plans need clearly established goals, such as to achieve full pain relief or to decrease pain to bearable levels.

Guideline 10

Analgesia that is tailored for a specific pain diagnosis is most likely to be effective in relieving pain.

Guideline 11

Analgesia induced side effects (constipation, anorexia, nausea, drowsiness, confusion, falls) may be more troublesome than the pain and may have serious consequences for residents. Side effects can often be anticipated and treated or avoided.

Guideline 12

Regular (around the clock) administration of analgesia is the most effective treatment for persistent pain.

Guideline 13

The need for short-acting analgesia for breakthrough pain should be anticipated and prescribed on an as needed (PRN) basis.

Guideline 14

Short acting analgesia given prior to an activity can be effective at reducing predictable (incident) pain.

Guideline 15

Choice of medications should take into account residents' co-existing medical conditions.

Guideline 16

Referral to pain specialists or pain clinics for assessment and development of a treatment plan may be helpful for residents with intractable pain.

Guideline 17

Cognitive-behavioural therapies (CBT) may help some residents to better manage their pain.

Guideline 18

Therapeutic exercise can decrease pain. Strengthening, stretching and aerobic exercises can be beneficial in increasing function and improving mood, as well as reducing pain intensity.

Guideline 19

For residents who are able to provide feedback on their experience, physical therapies, such as superficial heat and Transcutaneous Electrical Nerve Stimulation (TENS), can be helpful in reducing pain intensity in the short term.

Guideline 20

Pain on movement can be minimised by using appropriate manual handling techniques and equipment.

Guideline 21

Use of Complementary and Alternative Medicine (CAM) therapies may be helpful and can complement other pain management strategies.

Section 3: Organisational Issues Relating to Pain Management

Guideline 22

Objective and quantifiable clinical indicators based on best available evidence should be developed to guide clinical practice.

Guideline 23

Residents and their families should be included in all aspects of the pain management process.

Guideline 24

Education programmes to update staff about state-of-the-art principles of pain management, consistent with their scope of practice, should be available on a regular basis.

References:

1. The Australian Pain Society. (2005). *Pain in Residential Care Facilities: Management Strategies.* North Sydney, NSW.

Section 1
Pain Identification and Assessment

Explanation of The Pain Management Guidelines

The PMGs were developed directly from the *Pain in Residential Aged Care Facilities: Management Strategies*[1]. Throughout the text there are page references to guide you to a more detailed explanation contained in that document. It is suggested that you consult the complete *Pain in Residential Aged Care Facilities: Management Strategies*[1] document before making changes to policies, procedures and clinical practice.

Section 1: Pain Identification and Assessment

Guideline 1

Pain identification is an ongoing process that should occur:

- On admission
- In the event of a significant change in a resident's condition
- Any time pain is suspected
- At least every three months.

Any changes in residents' behaviours or conditions should be treated as suspicious and pain should be considered as a possible cause of the changes.

On admission, background information about pain status should be obtained as a baseline. If pain is identified at this time treatment protocols should be followed. If the resident is pain free on admission, regular reviews of pain status and behaviour will assist on-going pain management. The possibility of pain being a problem should be revisited at least every three months.

For further information refer to the *Pain in Residential Aged Care Facilities: Management Strategies*[1] pages: 1-6

Guideline 2

Pain identification requires a two-part approach, using staff observation techniques and residents' self reports of pain.

The most accurate and reliable source of information about a resident's pain is the resident's own report. Self report is always the first avenue that should be used to identify pain. All residents who are able to communicate should be asked about their pain using open-ended questions such as "does it hurt anywhere?" or "do you have any aches, pains or soreness?"

Staff should also observe residents for pain related behaviours that could indicate a new pain or increased severity of an existing pain. Signs of pain can include:

- Facial expressions such as grimacing or frowning
- Vocalisation such as sighing, moaning, groaning or calling out

- Body movements such as tense posture, fidgeting, guarding, increased pacing or rocking, restricted movement
- Changes in social interactions such as aggressive behaviour, withdrawal, disruptive behaviour
- Alterations in activity such as changes in appetite, changes in sleep patterns, increased wandering, cessation of routines
- Mental status changes such as deteriorating cognitive status, crying, increasing confusion, distress or irritability.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies*[1] pages: 1-6

Guideline 3

Pain needs to be properly diagnosed so that appropriate and effective management strategies can be planned. Diagnosis will explore the specific type of pain being experienced.

An accurate diagnosis of pain, whenever possible, is essential to allow for planning of appropriate treatment strategies. There are three major types of pain:

NOCICEPTIVE PAIN – pain related to the stimulation of pain receptors. Nociceptive pain can be classified as ***visceral*** or ***somatic***. Visceral pain is related to organs such as the liver, heart, gut etc. Visceral pain is often described as deep, squeezing or a dull ache. Visceral pain can be referred to other sites and is often poorly localised. Visceral pain can include pain related to intra-abdominal, cardiac, pulmonary and liver conditions. Nociceptive pain can also be somatic, that is, related to pain stimuli in the skin, muscles or bones. Somatic pain is generally well localised, and may be described as aching, gnawing or sharp. Somatic pain can include arthritis and musculoskeletal conditions.

NEUROPATHIC PAIN – pain related to damage to the nervous system. This sort of pain is often described as burning, shooting or tingling. Neuropathic pain can be related to diabetic neuropathy, CVA, phantom limb pain and sciatica. This type of pain is often less responsive to common analgesics.

PAIN RELATED TO PSYCHOLOGICAL/ PSYCHIATRIC FACTORS – this type of diagnosis is considered when psychological and/or psychiatric factors are considered to play a major role in the onset or severity of the pain. Psychopathology must be identified if this pain diagnosis is to be considered. Treatment of the underlying problem is essential.

A further category of pain is described by the American Geriatrics Society[2]. This pain is related to mixed or unknown mechanisms, such as some forms of widespread pain or recurrent pain such as headaches with no obvious associated pathology.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies*[1] pages: 7-8

Guideline 4

A thorough pain assessment explores multiple factors. These include:

- **Pain history**
- **General medical history**
- **Physical examination**
- **Physical impact of the pain**
- **Social impact of the pain**
- **Psychosocial factors related to the pain**
- **A review of medications and treatments**
- **Severity and intensity of the pain**
- **Prognosis.**

A thorough assessment of pain is essential prior to planning a treatment regime. Pain assessment must consider all of the factors listed. An assessment of this depth is completed after pain has been identified as an issue for a resident.

It may not be necessary to complete a pain assessment in this depth for a pain that is considered short-term or transitory and is relieved easily with simple measures. Instead, an adapted assessment could be completed to suit the situation.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies*[1] pages: 8-11, 65-66

Guideline 5

The use of an appropriate, structured pain assessment tool will facilitate thorough assessment of a resident's pain.

For residents who are able to communicate, the Modified Residents' Verbal Brief Pain Inventory (M-RBVPI)[3] is the pain assessment tool recommended by the APS. The M-RVBPI is a modified version of the Brief Pain Inventory[4] that was developed specifically for use in RACFs. It asks the resident about a number of aspects of their pain including pain intensity and the impact of the pain on quality of life and various activities.

Pain assessment is more problematic for residents with dementia or severe cognitive impairment. The Abbey Pain Scale[5] or the Pain Assessment in Advanced Dementia Scale (PAINAD)[6] may both be useful tools to assess pain in this group of residents. Both of these tools guide observation of behaviours that may be related to pain.

The appropriate tools should be chosen for each resident, and used consistently for assessing that person.

It is important to assess pain on movement as well as at rest. Movement such as transferring or repositioning a patient can exacerbate pain and may therefore impact on functional ability. Increased pain on movement may make people reluctant to move and complete required activities.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies*[1] pages: 8-13, 14-17, 67, 69-71, 73-75

Guideline 6

A uni-dimensional pain assessment scale can be used frequently for ongoing evaluation of pain intensity and response to treatment.

A uni-dimensional scale only assesses one dimension of pain, most often the severity of the pain. Unidimensional pain assessment tools include:

NUMERIC RATING SCALE - pain is rated on a scale of zero to 10, with zero indicating no pain and 10 meaning the worst possible pain.

VERBAL DESCRIPTOR SCALE - pain is described using categories such as no pain, mild pain, moderate pain, severe pain, very severe pain, worst possible pain.

These pain scales can be used daily or more frequently to document changes to pain severity and the effectiveness of treatment. However, this may not be possible with cognitively impaired residents, but should be attempted to determine each resident's ability.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies*[1] pages: 13-14, 16, 68, 72-73

References:

1. The Australian Pain Society. (2005). *Pain in Residential Aged Care Facilities: Management Strategies.* North Sydney, NSW
2. The American Geriatrics Society. (2002). Guidelines on Persistent Pain in the Older Adult. *Journal of The American Geriatrics Society,* 50, S205-S224.
3. Auret, K. A., Toye, C., Goucke, R., Kristjanson, L. J., Bruce, D., & Schug, S. (2008). Development and testing of a modified version of the Brief Pain Inventory for use in residential aged care facilities. *Journal of the American Geriatrics Society*, 56 (2), 301-306.
4. Cleeland, C. S. (1989). Measurement of pain by subjective report. In C. R. Chapman & J. D. Loeser (Eds.), *Advances in pain research and therapy: Vol 12. Issues in pain management* (pp 391-403). New York: Raven Press.
5. Abbey, J., Piller, N., Bellis, A., Esterman , A., Parker, D., Giles, L., & Lowcay, B. (2004). The Abbey Pain Scale: A 1 minute numerical indicator for people with end stage dementia. *International Journal of Palliative Nursing*, 10, 6-13
6. Warden, V., Hurley, A., & Volicer, L. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *Journal of American Medical Directors Association*, 4, 9-15

Section 2
Treatment Strategies

Section 2: Treatment Strategies

Guideline 7

A combined treatment plan using pharmacological and non-pharmacological therapies is more likely to relieve pain than a single treatment option.

Combining analgesic use with non-pharmacological therapies such as exercise or relaxation can offer greater chance of relieving pain and may require less medication to be used, thus minimising the side effects of analgesia.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies page*: 21

Guideline 8

Multidisciplinary collaboration enhances pain management. The multidisciplinary team may consist of the resident and their family, nurses, doctors, physiotherapists, occupational therapists, other allied health professionals and care workers.

Developing a pain management treatment plan requires the input of a number of health professionals, all of whom can offer expertise in a particular area of treatment. This allows for a holistic treatment plan to be developed. The resident and their family should always be considered an integral part of the pain management team.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 7, 18-20

Guideline 9

Pain management plans need clearly established goals, such as to achieve full pain relief or to decrease pain to bearable levels.

Individual goals of care should be established for each resident.

It is not always possible to achieve complete relief of pain and it is important to be honest about this with residents. Sometimes a realistic goal of therapy may be to reduce pain to a more manageable level. Goals of treatment need to be discussed with residents and their families and decisions made about the need for balancing the treatment of pain with the potential side effects of the treatment. Maintaining alertness and optimal mobility may be a high priority for some residents, whereas this may be a less important issue for residents with palliative care needs.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies page*: 21

Guideline 10

Analgesia that is tailored for a specific pain diagnosis is most likely to be effective in relieving pain.

Different analgesics are effective at treating different types of pain, and therefore medications must be prescribed that are appropriate for a specific pain diagnosis. For example, paracetamol is an effective analgesic for treating musculoskeletal pain, whereas antidepressant or antiepileptic medication may be more helpful for treatment of neuropathic pain.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 21-28

Guideline 11

Analgesia induced side effects (constipation, anorexia, nausea, drowsiness, confusion, falls) may be more troublesome than the pain and may have serious consequences for residents. Side effects can often be anticipated and treated or avoided.

Most side effects of analgesia are well documented and as such can be anticipated. The need to reduce pain with the use of medication must be balanced against the possibility that the side effects of the medication may be worse than the pain itself. The selection of analgesia is based on the likelihood of gaining pain relief with the least possible side effects.

Side effects such as drowsiness, confusion or falls require careful consideration and planning of care to ensure that resident's cognition, function and safety is maintained. The balance of pain relief and unwanted side effects needs to be discussed fully with the resident, family and pain management team. Other side effects, such as constipation and nausea, are treatable or even preventable with a suitable plan of care.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 21-28

Guideline 12

Regular (around the clock) administration of analgesia is the most effective treatment for persistent pain.

Persistent or frequently recurring pain requires regular doses of analgesia. Pain that is treated promptly is easier to manage than pain that is left to escalate before treatment is commenced. Controlled release analgesics, if prescribed, should always be given regularly for persistent pain.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 21-28

Guideline 13

The need for short-acting analgesia for breakthrough pain should be anticipated and prescribed on an as-needed (PRN) basis.

Controlled release or around the clock doses of analgesia may not always control pain adequately, with "breakthrough" pain resulting. Therefore, short acting analgesia should be available on an as-needed basis to treat these unexpected exacerbations of pain.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies* pages: 21-28

Guideline 14

Short acting analgesia given prior to an activity can be effective at reducing predictable (incident) pain.

Some pain events can be predicted, such as pain on movement, repositioning or during wound dressing changes. Analgesics are likely to be more effective if given prior to the activity that induces or aggravates the pain. In this way pain control is likely to be more effective and the activity can be completed with minimum distress for the resident.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 21-28, 42-43

Guideline 15

Choice of medications should take into account residents' co-existing medical conditions.

Existing medical conditions should always be considered when prescribing medication, so that additional medications do not contribute further to co-morbidities. Existing medication may also impact on the absorption and excretion of medications and allowances may need to be made to dosages. The selection of medication should also be considered in the context of possible age related changes in drug sensitivity, efficacy, metabolism and possible side effects.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 21-28

Guideline 16

Referral to pain specialists or pain clinics for assessment and development of a treatment plan may be helpful for residents with intractable pain.

Referral to a pain clinic or pain specialist should be considered if troublesome pain persists after reasonable trials of pharmacological and non-pharmacological therapies.

Interventional pain management techniques such as local anaesthetic blocks and corticosteroid injections may be considered in some situations.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies page*: 19

Guideline 17

Cognitive-behavioural therapies (CBT) may help some residents to better manage their pain.

Cognitive-behavioural therapies may be helpful adjunct therapies for cognitively intact residents, or residents with mild cognitive impairment, who are interested in trying different approaches. Residents who are experiencing pain related insomnia, depression or anxiety, may get particular benefit from these therapies. Residents must be able to actively participate in these therapies.

CBT can include relaxation, biofeedback, education, learning coping strategies and thought restructuring. CBT can provide more adaptive ways of thinking and acting, as well as a better understanding of pain and pain control techniques. CBT is normally administered by a psychologist with training in pain management techniques or an allied health professional working in consultation with a psychologist. CBT can be delivered in a group setting or on an individual basis.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 29-35

Guideline 18

Therapeutic exercise can decrease pain. Strengthening, stretching and aerobic exercises can be beneficial in increasing function and improving mood, as well as reducing pain intensity.

Exercise has been shown to reduce the intensity of pain experienced by older people with musculoskeletal disorders by up to 30%[1-2] and may also improve the mood of older people with depression. Exercise also offers the potential benefits of increased strength and improved functional capacity.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 37-39

Guideline 19

Physical therapies, such as superficial heat and Transcutaneous Electrical Nerve Stimulation (TENS), can be helpful in reducing pain intensity in the short term, for residents who are able to provide feedback on their experience.

Most physical modalities for pain relief have only brief periods of efficacy and are therefore not useful for the management of persistent pain. Repeated applications may be helpful for a limited time during episodes of acute pain.

Residents must be able to communicate with staff to determine the correct placement of heat packs or TENs electrodes if these treatments are being considered. Residents also need to be able to communicate any discomfort related to the treatment, so that excess heat or excess stimulation from a TENS unit can be reported immediately and the device can be adjusted or removed.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies pages*: 40-42

Guideline 20

Pain on movement can be minimised by using appropriate manual handling techniques and equipment.

Pain can be exacerbated during manual handling because of increased pain sensitivity or because an activity requires a joint to move beyond its range of movement. Range of movement in joints is often impaired in older people with conditions such as osteoarthritis. An assessment of the manual handling needs of a resident must include these areas. Care plans can then be developed that reflect the needs of the resident. Physiotherapy and occupational therapy consults may be helpful in adapting manual handling protocols to reduce pain on movement.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies* pages: 42-43

Guideline 21

Use of Complementary and Alternative Medicine (CAM) therapies may be helpful and can complement other pain management strategies.

About 40% of older people report using CAM therapies for treatment of conditions such as arthritic pain and depression or anxiety[3]. Use of CAM therapies may be helpful in reducing polypharmacy and analgesic doses. However, care must be taken when using CAM therapies as there is limited available research about the safety and effectiveness of many of these treatments.

CAM therapies may include:

- Biologically based therapies such as dietary supplements, herbal remedies and aromatherapy products
- Alternative medical systems include traditional Chinese medicine and use of related practices such as acupuncture
- Mind-body interventions such as meditation, prayer, art and music therapies
- Manipulative or body-based therapies such as chiropractic or osteopathic manipulation
- Energy therapies such as reiki and therapeutic touch.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies* pages: 45-49, 76-77

References:

1. Fransen, M., McConnell, S., & Bell, M. (2002). Therapeutic exercise for people with osteoarthritis of the hip or knee: A systematic review. *Journal of Rheumatology*, 29 (8), 1737-1745.

2. Fransen, M., McConnell, S., & Bell, M. (2003). Exercise for osteoarthritis of the hip or knee. *Cochrane Database Systematic Review*, 3, CD004286

3. Astin, J.A. (1998). Why patients use alternative medicine: Results of a national study. *British Medical Journal*, 279 (19), 1548-1553

Section 3
Organisational Issues

Section 3: Organisational Issues Relating to Pain Management

Guideline 22

Objective and quantifiable clinical indicators based on best available evidence should be developed to guide clinical practice.

The *Aged Care Act* (1997) stipulates that all residents should be "as free as possible from pain" and provides criteria to demonstrate that this outcome has been met. These criteria must be met as part of the accreditation process for all RACFs. The use of specific quality indicators may enhance the quality management process.

Research has found that freedom from pain was considered the most important end of life priority, ahead of being at peace and being with loved ones[1]. Assurance of high quality evidence-based pain management in the residential aged care sector is important as pain affects both quality of life and physical function.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies* pages: 51-56

Guideline 23

Residents and their families should be included in all aspects of the pain management process.

The provision of holistic care requires the involvement of residents and their families in the planning, implementation and evaluation of care. Residents and their families are a valuable source of information about the pain experience. Fears about pain and treatment of pain may be allayed for the resident and their family when they are included in the decision making process.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies* pages: 51-60

Guideline 24

Education programmes to update staff about state-of-the-art principles of pain management, consistent with their scope of practice, should be available on a regular basis.

A systematic education programme for staff at all levels is an important component of any initiative to enhance pain management in the residential aged care sector. Education sessions can be used to reinforce the key messages of pain management strategies and to incorporate new evidence into practice.

For further information refer to *Pain in Residential Aged Care Facilities: Management Strategies* pages: 60-61

References:

1. Steinhauser, K.E., Christakis, N.A., Clipp, E.C., McNeilly, M., McIntyre, L., Tulsky, J.A. (2000). Factors considered important at the end of life by patients, family, physicians and other care providers. *Journal of the American Medical Association*, 284, 2476-2482

Information Sheet for Visiting General Practitioners

Template for Information Sheet for Visiting General Practitioners

General Practitioners (GPs) play a vital role in providing care for residents. However, they are not permanent staff at your facility and so do not have the option of attending induction days that teach them how your facility works. To assist GPs that visit your facility, especially those that attend infrequently, we have developed a sample information sheet, that you can alter to suit your facility, to give to visiting GPs. **The sections of the text that are highlighted need to be customised to suit your facility**. There are also several options offered in some places to guide you – the one you choose will depend on the services you offer.

A copy of this information sheet, saved as a word document, is available on the CD so that you can quickly and easily make your own sheet.

Information Sheet:
Visiting General Practitioners

Welcome to our facility. We have a commitment to reducing the incidence of pain experienced by our residents and would like to update you on the measures we are taking to ensure that our residents are comfortable and as pain free as possible.

Pain identification and assessment

Identifying pain and completing a comprehensive assessment of residents on a regular basis is an essential part of managing pain effectively. We complete a pain identification and assessment process at the following times:

- on admission
- at least every three months
- any time pain is suspected
- in the event of a significant change in a resident's condition.

Assessment Tools and Documentation

To facilitate pain assessment we use either the Residents' Verbal Brief Pain Inventory (for cognitively intact residents) or the Abbey Pain Scale (for residents with dementia or cognitive impairment). Both of these assessment tools have been validated by research and are easy to use. A copy of both is attached. Completed assessments are filed in the resident's health record in the "Assessment" section.

We also use a verbal descriptor rating scale for on-going pain assessment, including assessing the effectiveness of treatment. This scale asks residents to pick one of five descriptions of pain that best describes them. The choices are:

- no pain
- mild pain
- moderate pain
- very severe pain
- worst possible pain.

This information is recorded on the observation chart and is also filed in the "Assessment" section of the health record.

Equipment for Assessment

For your convenience, equipment that you may require when completing a physical assessment (tendon hammer, stethoscope etc) is available in the nurses' office.

Pain Management Strategies

We have adopted a multi-disciplinary approach to pain management, where members of the nursing staff, care workers and allied health professionals all have input into assessment and treatment of pain. The resident and their family are also actively involved in this process.

Team Meetings

All visiting General Practitioners are encouraged to attend clinical team meetings, which are held on the first Monday of the month at 12:30. Alternatively, if you wish to hold a team meeting for a resident with specific difficulties this can be arranged by speaking with the nurse coordinator.

If you wish to meet with nursing staff at other times to discuss resident care we recommend that you ring first to ensure that there will be a staff member available to speak with you. Meal times and shift change times are often difficult times to find staff and we can recommend times that are easier to find staff members to assist you.

Available Treatment Strategies

We actively promote the use of both pharmacological and non-pharmacological pain management strategies. Our staff are able to offer:

- a range of therapeutic exercise classes supervised by a physiotherapist
- a range of mobility and comfort aids provided with occupational therapist input
- heat packs (we use wheat packs provided by the resident/family)
- TENS machine used with physiotherapist supervision
- Aromatherapy for relaxation with the input of a trained therapist.

We are also able to assist residents and families who request the input of complementary therapists for therapies such as massage, reiki and reflexology, by providing the contact details of reputable practitioners. Cost for these therapies are borne by the resident/family.

Medication Administration

Alternative 1:
There is a registered nurse on duty in this facility 24 hours per day, and as such we are able to dispense a range of prescribed medications, including Schedule 8 medications and PRN doses of medication for breakthrough pain as requested. Please note that medications are sourced from

private pharmacies and it can take 24 hours to fill a new script. Also, because residents/families bear the cost of medications they may sometimes express concern if medications are costly.

Alternative 2:
We do not have a registered nurse on duty 24 hours a day in this facility, and as such there are some restrictions to the type of medications that we are able to provide for residents. All regular doses of medications are packaged in a blister pack by the local pharmacy and can include any oral medications including oral preparations of Schedule 8 medications. If you change a prescription for a medication please note that it can take up to 48 hours for the new blisterpack to be made by the pharmacy.

Administering as needed (PRN) medications

Alternative 1:
If a resident requires PRN doses of medication we are able to give oral medications, including schedule 8 medications, providing the prescription clearly states what the medication is to be given for. For example:

Oxycodone 5 mg, orally, to be given as needed every 4 hours, for lower back pain.

Alternative 2:
We are not able to administer parenteral medications in this facility because we do not have 24 hour cover by trained staff.

Documentation Required for Medication

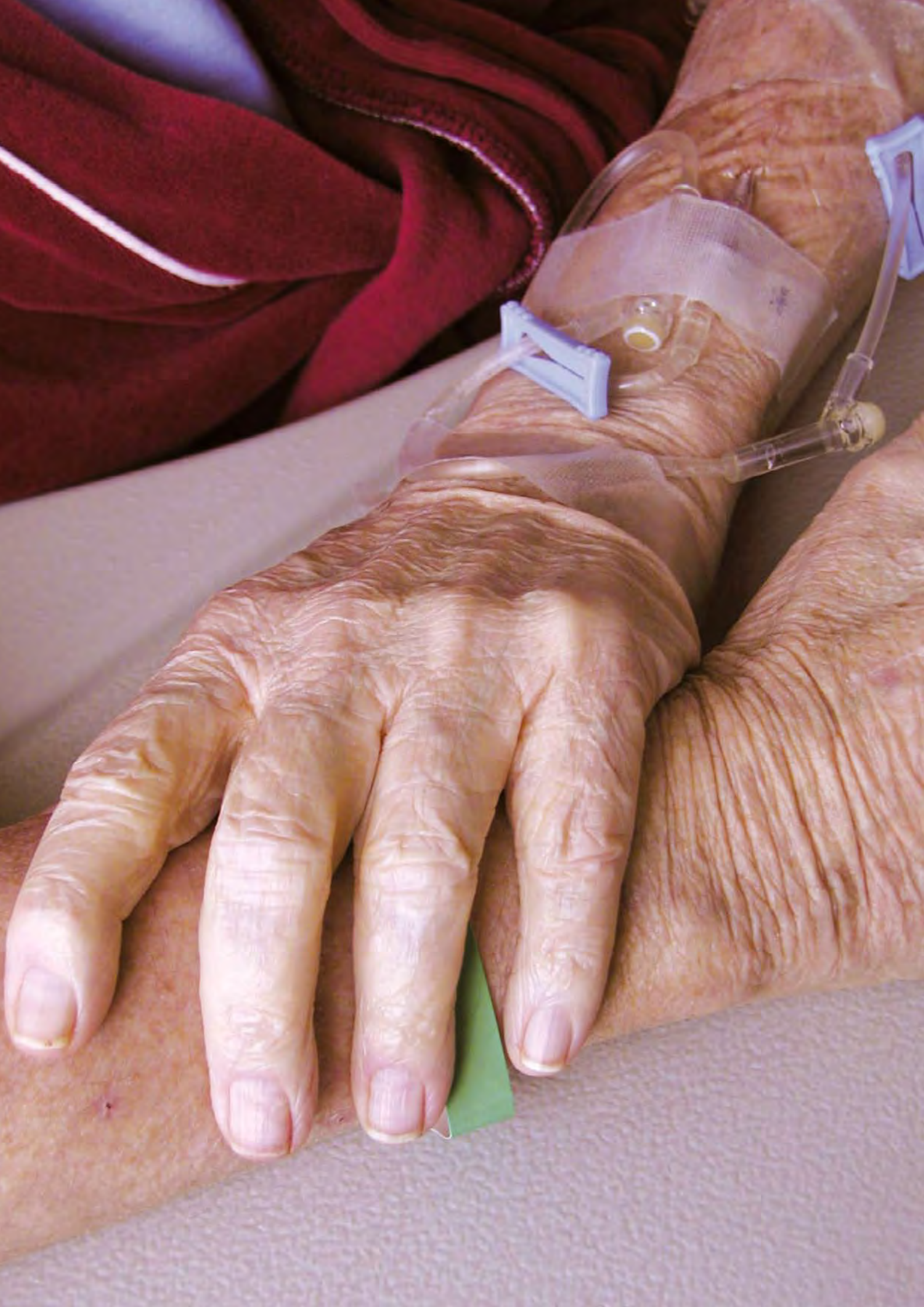
We require scripts for each medication that a resident is prescribed to be written and left in the front of the resident's file. We will send a reminder to your surgery at least a week before we need the scripts if new ones are required.

We also require medication charts to be completed on a regular basis. We use medication charts that last for a three month period, so will ask that you complete a new one at least three days prior to the completion of the chart. A reminder will be sent to you at your surgery.

Glossary of Pain Related Terms

Pain in Residential Aged Care Facilities: Implementation Kit to Accompany the Residential Aged Care Pain Management Guidelines

Acute pain	Pain of rapid onset and short duration
Adjuvant analgesia	A medication added to a treatment regime to improve or enhance the therapeutic outcome
Allodynia	A condition in which a normally painless occurrence is perceived as painful
Analgesia	The absence of pain. Often used to describe pain relieving medications
Breakthrough pain	Pain experienced when analgesic medication fails to provide complete pain relief
Chronic pain	Pain of long duration, often classified as lasting for longer than three months
Controlled release medication	Medication that is formulated to provide long term pain relief, often for 12 hours or more
Hyperalgesia	An excessive sensitivity to pain
Incident Pain	Pain experienced during a specific activity, especially movement
Neuropathic	Related to disease or damage of a nerve/s
Nociceptive	Related to the sensation of pain experienced because of stimulus of free nerve endings (nociceptors) that transmit pain impulses
Non-pharmacological	Not involving medication
Opioid	Substances related to opium that relieve pain. Also known as Schedule 8 medications. Previously known as narcotic drugs
Opioid naive	A patient who has not taken an opioid medication before
Persistent pain	Pain that continues for an extended period of time
Pharmacological	Related to medication
Predictable pain	Pain that can be foreseen, such as pain on movement
Round-the-clock dosing	Medication given at regular intervals throughout the day/night
Somatic	Relating to structures of the body wall, such as skin, muscles
Titrate	To determine required medication dose by regularly increasing amount given by a standard amount
Visceral	Relating to internal organs



Checklists and Audit Tool

Pre-implementation Audit Tool

This tool is a self-directed guide to examining pain management practice in your facility. It will help you to identify current strengths in practice and will highlight areas that need consideration prior to commencing implementation of the Australian *Pain Society's Pain in Residential Aged Care Facilities: Management Strategies*.

SECTION 1: THE PAIN MANAGEMENT TEAM				
	Yes	No	N/A	Comments
1. Have you sought support for implementing the pain management guidelines from senior management/ administration?				
2. Are staff in the facility aware and supportive of the proposed changes?				
3. Are residents and families aware of and supportive of the proposed changes?				
4. Have you discussed the formation of a pain management team with key stakeholders: • Nursing staff • Care workers • General Practitioners • Allied health staff • Pharmacist?				
5. Have you identified other sources of assistance in your area: • A pain specialist • A geriatrician • The ACAT team • A palliative care service • A pain clinic?				
6. Do you have regular pain team meetings scheduled?				
SECTION 2: RESOURCES				
	Yes	No	N/A	Comments
7. Can staff incorporate new pain management strategies into their workload?				
8. Can you develop a new pain management coordinator role?				
9. Do you have adequate equipment: • lifting devices • comfort aids (mattresses, sheepskins etc) • hot packs • TENS machines?				
10. Do you have access to up-to-date educational materials relating to pain management?				

SECTION 3: PAIN IDENTIFICATION AND ASSESSMENT				
	Yes	No	N/A	Comments
11. Do you have tools available to identify pain in residents with communication difficulties: • picture cards for residents with • dysphasia, dysarthria, deafness • cards for residents from culturally cards for residents from culturally and linguistically diverse backgrounds				
12. Do you have information about pain management available for residents and families?				
13. Do you have pain assessment tools available that have been validated by research?				
14. Do you have assessment tools that are suitable for cognitively intact and cognitively impaired residents?				
15. Do the tools that you use address the main facets of pain assessment: • the impact of pain on function • the impact of pain on cognition • the impact of pain on quality of life?				
16. Are staff familiar with the use of pain assessment tools?				
SECTION 4: TREATMENT STRATEGIES				
	Yes	No	N/A	Comments
17. Do current medication guidelines clearly articulate roles of different levels of staff in medication administration?				
18. Do residents have the option of selfmedicating where appropriate?				
19. Do you have guidelines in place for the prescription, use and storage of Schedule 8 medications?				
20. Do you have arrangements in place that allow for the administration of PRN medications on a 24 hour basis?				
21. Are regular pharmacy checks of residents' medication charts scheduled?				
22. Are guidelines available regarding the use of physical therapies such as hot packs and TENS machines?				

23. Are suitable exercise programmes developed with physiotherapist input available to all residents?				
24. Are guidelines available regarding the use of complementary and alternative therapies?				
25. Are the outcomes of pain treatments documented by staff?				
SECTION 5: ORGANISATIONAL ISSUES				
	Yes	No	N/A	Comments
26. Is there a policy that describes pain assessment procedures, including: When assessments are conducted • Who is responsible for assessment • Roles of staff not directly responsible for assessment • Which assessment tools are to be used • How assessments are to be documented?				
27. Is there a policy in place that describes the role of facility staff in administering medications, including: • Schedule 8 medications • PRN medications?				
28. Have clinical indicators been developed to guide pain related quality management projects?				
SECTION 6: PAIN MANAGEMENT EDUCATION				
	Yes	No	N/A	Comments
29. Do all staff have access to regular education updates about pain management?				
30. Have all staff received education about the use of pain assessment tools?				
31. Have all staff received education about documentation relating to pain management?				
32. Has information about changes to pain management practices been made available to all staff and General Practitioners?				

Post-implementation Audit Tool

This tool is a self-directed guide to examining pain management practice in your facility. It will help you to identify current strengths in practice and will highlight areas that need consideration following the implementation of the Australian Pain Society's *Pain in Residential Aged Care Facilities Management Strategies*. It is suggested that you chose a cross section of residents' notes to examine as part of this audit.

SECTION 1: PAIN MANAGEMENT DOCUMENTATION				
	Yes	No	N/A	Comments
1. Have all residents had a pain assessment completed within the timeframe specified in your policy				
2. Are pain assessment tools completed correctly?				
3. Is there evidence of treatment being initiated for all residents identified as having pain?				
4. Do the residents' care plans demonstrate input from the multidisciplinary team, including: • Nursing staff • Resident/family • General Practitioners • Occupational Therapist • Physiotherapist • Other practitioners?				
5. Does the pain management care plan show evidence of pharmacological and nonpharmacological treatments?				
6. Is documentation related to medication administration completed appropriately?				
7. Are the outcomes of treatments documented?				
SECTION 2: ORGANISATIONAL ISSUES				
	Yes	No	N/A	Comments
8. Is there evidence that policies relating to pain assessment are being adhered to?				
9. Is there evidence that policies relating to medication administration are being adhered to?				
10. Have regular pharmacy checks been conducted and the findings acted upon?				
11. Have clinical indicators been met?				
12. Has pain management education been held on regular basis?				
13. Have all the staff attended a pain management update?				
14. Are pain management team meetings held on a regular basis?				

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 to 6

Name of resident: _____

Name and designation of person completing the scale: _____

Date: _____ Time: _____

Latest pain relief given was _____ at _____ hours

Q1. Vocalisation
eg. whimpering, groaning, crying
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q1 ☐

Q2. Facial Expression
eg. looking tense, frowning, grimacing, looking frightened
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q2 ☐

Q3. Change in Body Language
eg. fidgeting, rocking, guarding part of body, withdrawn
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q3 ☐

Q4. Behavioural Change
eg. increased confusion, refusing to eat, alteration in usual patterns
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q4 ☐

Q5. Physiological Change
eg. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q5 ☐

Q6. Physical Changes
eg. skin tears, pressure areas, arthritis, contractures, previous injuries
Absent - 0 Mild - 1 Moderate - 2 Severe - 3 Q6 ☐

- Add scores for 1 - 6 and record here → **Total Pain Score** ☐
- Now tick the box that matches the Total

☐ 0-2 - No Pain ☐ 3-7 - Mild ☐ 8-13 - Moderate ☐ 14 + - Severe

- Finally, tick the box which matches the type of pain

☐ Chronic ☐ Acute ☐ Acute on Chronic

Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
Funded by the JH & JD Gunn Medical Research Foundation 1998 - 2002

Pain Assessment IN Advanced Dementia - PAINAD

	0	1	2	SCORE
Breathing Independent of Vocalisation	Normal	Occasional laboured breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations	
Negative Vocalisation	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial Expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigids. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
			TOTAL	

Warden, Hurley and Volicer 2003

Pain Assessment IN Advanced Dementia - PAINAD

Item definitions

Breathing

1. **Normal breathing**
   DESCRIPTION: Normal breathing is characterized by effortless, quiet, rhythmic (smooth) espirations.
2. **Occasional labored breathing**
   DESCRIPTION: Occasional labored breathing is characterized by episodic burst of harsh, difficult or wearing respirations.
3. **Short period of hyperventilation**
   DESCRIPTION: Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. **Noisy labored breathing**
   DESCRIPTION: Noisy labored breathing is characterized by negative sounding respirations or inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. **Long period of hyperventilation**
   DESCRIPTION: Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. **Cheyne-Stokes respirations**
   DESCRIPTION: Cheyne-Stokes respirations is characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnoea (cessation of breathing).

Negative Vocalization

1. **None**
   DESCRIPTION: None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. **Occasional moan or groan**
   DESCRIPTION: Occasional moaning is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. **Low level speech with a negative or disapproving quality**
   DESCRIPTION: Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. **Repeated troubled calling out**
   DESCRIPTION: Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.

5. **Loud moaning or groaning**
   DESCRIPTION: Loud moaning is characterized by mournful or murmuring sounds, wails or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. **Crying**
   DESCRIPTION: Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. **Smiling or inexpressive**
   DESCRIPTION: Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. **Sad**
   DESCRIPTION: Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. **Frightened**
   DESCRIPTION: Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.
4. **Frown**
   DESCRIPTION: Frown is characterized by a downward turn of corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. **Facial grimacing**
   DESCRIPTION: Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. **Relaxed**
   DESCRIPTION: Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. **Tense**
   DESCRIPTION: Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. **Distressed pacing**
   DESCRIPTION: Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may by faster or slower.
4. **Fidgeting**
   DESCRIPTION: Fidgeting is characterized by restless movement. Squirming about or wriggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.
5. **Rigid**
   DESCRIPTION: Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).

6. **Fists clenched**
   DESCRIPTION: Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. **Knees pulled up**
   DESCRIPTION: Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).
8. **Pulling or pushing away**
   DESCRIPTION: Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.
9. **Striking out**
   DESCRIPTION: Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. **No need to console**
   DESCRIPTION: No need to console is characterized by a sense of well being. The person appears content.
2. **Distracted or reassured by voice or touch**
   DESCRIPTION: Distracted or reassured by voice or touch is characterized by a disruption in the behaviour when the person is spoken to or touched. The behaviour stops during the period of interaction with no indication that the person is at all distressed.
3. **Unable to console, distract or reassure**
   DESCRIPTION: Unable to console, distract or reassure is characterized by the inability to soothe the person or stop a behaviour with words or actions. No amount of comforting, verbal or physical, will alleviate the behaviour.

Warden V, Hurley AC, Volicer L. Development and psychometric scale. *Journal of American Medical Directus, 4(1)*: 9-15, 2003

Modified Residents' Verbal Brief Pain Inventory (M-RVBPI)

(Adapted from Cleeland, 1989, by the Australian Pain Society, 2005, & Toye et al., 2005)
Note: This questionnaire is to be answered at interview

Date: _____ Time: _____ Name: _____

1. Have you had any pain in the past 24 hours?
Prompts: An ache; feeling tender; hurting; feeling stiff and sore; headache.

Please tick: ☐ YES ☐ NO

USE THE PROMPTS FOR PAIN FROM THIS ITEM THROUGHOUT THE QUESTIONNAIRE, AS NEEDED

Now, bearing in mind the resident's usual abilities, and to assess the resident's pain on movement, please ask the resident to move in the way that he/she is usually able to move (e.g, walk, rise to a standing position and then sit down again, turn over in bed, bend and/or raise their arms and legs, as appropriate).

Please state movement(s) made _____

2. (a) Did you have any pain when you were moving just now?

Please tick: ☐ YES ☐ NO

(b) Where was the pain when you were moving? Show body map

Location(s) _____

(c) And how bad was your pain when you were moving, just now?

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

Note: use the flip chart showing these response options in large font, if the individual is able to see them. If the individual reports no pain using either of these two items, this is the end of the pain check.

Otherwise, please continue

3. Please tell me more about all the pain or pains you have had in the past 24 hours (show body map). Show me <u>all</u> the places where the pain is or has been.

List pain sites _____

_____

_____

Now please think about your pain overall, whether it is in one place or in more than one place.
Note: continue to use the flip chart showing No Pain/Mild/Moderate/Severe if the resident is able to read the font.

4. In the past 24 hours, how bad has the pain been at its worst?
Prompts: most troublesome, when it was as bad as it got.

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

5. In the past 24 hours, how bad has the pain been at its least?
Prompts: least troublesome or not there at all, when it was as good as it got.

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

6. How bad is your pain now?

Please tick: ☐ NO PAIN ☐ MILD ☐ MODERATE ☐ SEVERE

NOW CHANGE TO THE FLIP CHART SHOWING THE OPTIONS NO EFFECT - SEVERE EFFECT

7. In the past 24 hours, please tell me how much pain has had an effect on your walking ability (if applicable)?

Please tick here if the person is unable to walk (regardless of pain) ☐
Otherwise, please tick below:

☐ NO EFFECT ☐ MILD EFFECT ☐ MODERATE EFFECT ☐ SEVERE EFFECT

8. Please tell me how much pain has had an effect on your general activity in the past 24 hours?
Prompts: the things that you do each day (give appropriate examples such as eating breakfast, selecting clothing for the day, combing hair).

Please tick:

☐ NO EFFECT ☐ MILD EFFECT ☐ MODERATE EFFECT ☐ SEVERE EFFECT

9. In the past 24 hours, how much has pain had an effect on your interactions with other people?
Prompts: chatting, saying hello, answering when others speak to you, smiling at other people.

Please tick:

☐ NO EFFECT ☐ MILD EFFECT ☐ MODERATE EFFECT ☐ SEVERE EFFECT

THANK YOU

References:

1. Australian Pain Society (2005). *Pain in residential aged care facilities: Management strategies*
2. Cleeland, C. S. (1989). Measurement of pain by subjective report. In C. R. Chapman & J. D. Loeser (Eds.), *Advances in pain research and therapy: Vol 12. Issues in pain management* (pp 391-403). New York: Raven Press.
3. Auret, K. A., Toye, C., Goucke, R., Kristjanson, L. J., Bruce, D., & Schug, S. (2008). Development and testing of a modified version of the Brief Pain Inventory for use in residential aged care facilities. *Journal of the American Geriatrics Society*, 56 (2), 301-306.

Scoring the M-RVBPI

Items 2c, 4, 5, and 6 assess the intensity of pain as reported by the resident. These items are best used to obtain a picture of the level of the resident's pain experience that can be summarised in the Pain Intensity Summary.

Pain Intensity Summary

Item	Pain Feature	Presence/Absence (circle)		Severity (circle)			
1	Pain initially recalled in past 24 hours	YES	NO				
2c	Pain on movement			None	Mild	Moderate	Severe
4	Pain worst in past 24 hours			None	Mild	Moderate	Severe
5	Pain least in past 24 hours			None	Mild	Moderate	Severe
6	Pain now			None	Mild	Moderate	Severe

Responses to Items 7, 8 and 9 can be scored using the scale of 0 (no pain) to 3 (severe pain) and these scores can be summed to give an overall score for pain interference. This score can be documented in the Pain Interference Summary.

Pain Interference Summary

Area of interference	Circle & Transfer Score to Total Column					Total
	None	Mild	Moderate	Severe	Not applicable (tick)	
Walking	0	1	2	3		
General activity	0	1	2	3		+
Interactions	0	1	2	3		+
					Overall Total	=

Recommended Uses of Scores

Obviously, responses for pain intensity and scores for pain interference can be used for comparison purposes. This is especially important when trialling an intervention to reduce pain. However, responses and scores should also serve to alert staff to the need to implement such an intervention. Some key principles are that:

- Pain of moderate or severe intensity that cannot be controlled by existing measures needs urgent review.
- Scores of 6 and over for pain interference, or four and over when the resident cannot walk, also mean that urgent review is required.
- Pain of any level of intensity that recurs, lasts for long periods, and/or causes interference with walking, general activity, or interactions must prompt the implementation or review of pain management strategies.

Sample Documentation

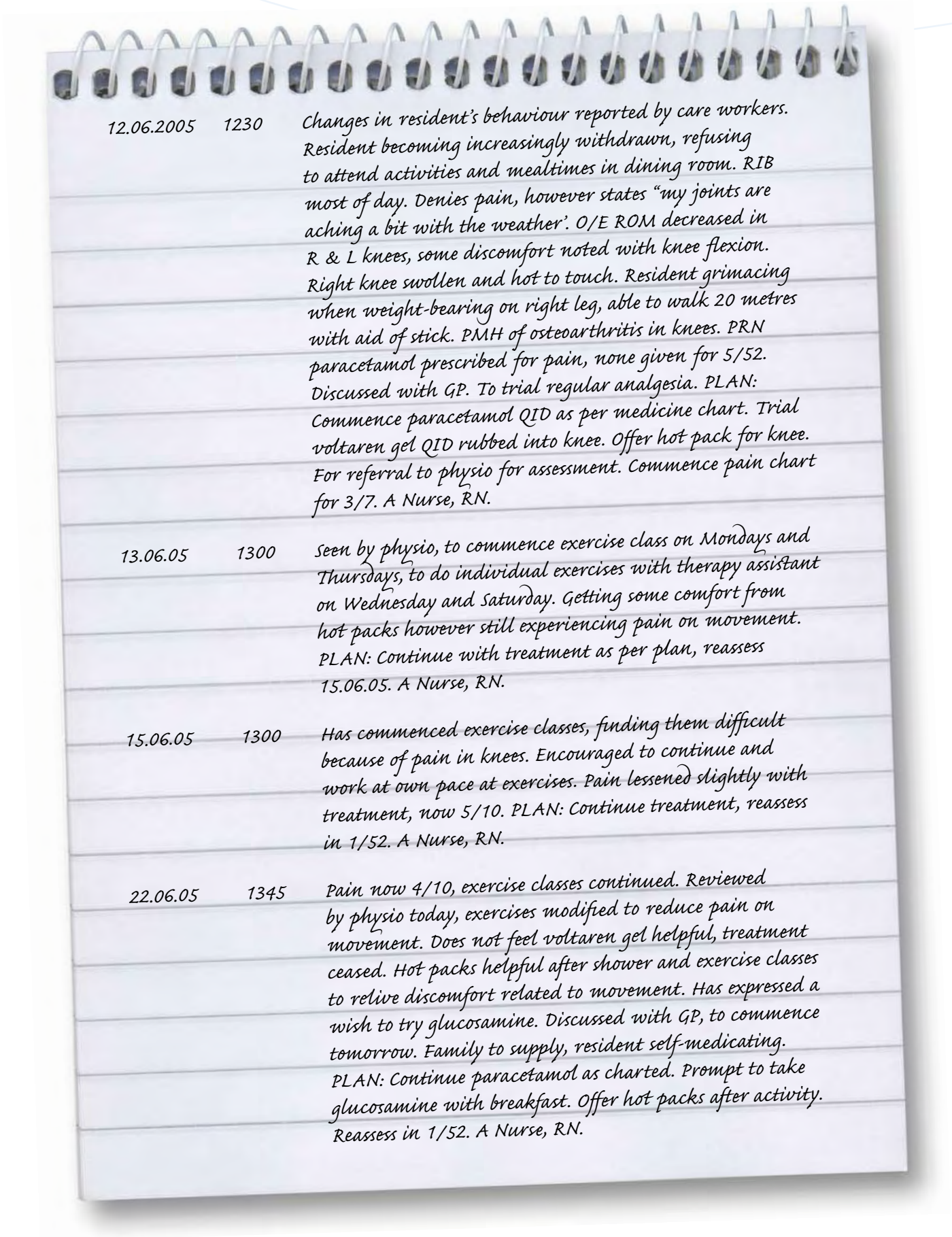
Sample Documentation

Documentation is the key to adequate pain assessment and on-going management. All staff in your facility that have a responsibility for recording in the residents' notes need to be educated about how to accurately and completely document all facets of pain management. Important points to remember are:

- Accurately record all identification and assessment data, either on a specific assessment form or in the resident's notes
- Always complete assessment forms completely as per the included instructions
- Record all proposed actions relating to pain management
- Record the effectiveness of all pain management strategies
- Document when follow-up actions are required.

The following samples of documentation relating to pain management may be helpful to use as a teaching aid or as a sample to follow in your facility.

Sample documentation from a resident's notes



12.06.2005 1230 Changes in resident's behaviour reported by care workers. Resident becoming increasingly withdrawn, refusing to attend activities and mealtimes in dining room. RIB most of day. Denies pain, however states "my joints are aching a bit with the weather'. O/E ROM decreased in R & L knees, some discomfort noted with knee flexion. Right knee swollen and hot to touch. Resident grimacing when weight-bearing on right leg, able to walk 20 metres with aid of stick. PMH of osteoarthritis in knees. PRN paracetamol prescribed for pain, none given for 5/52. Discussed with GP. To trial regular analgesia. PLAN: Commence paracetamol QID as per medicine chart. Trial voltaren gel QID rubbed into knee. Offer hot pack for knee. For referral to physio for assessment. Commence pain chart for 3/7. A Nurse, RN.

13.06.05 1300 Seen by physio, to commence exercise class on Mondays and Thursdays, to do individual exercises with therapy assistant on Wednesday and Saturday. Getting some comfort from hot packs however still experiencing pain on movement. PLAN: Continue with treatment as per plan, reassess 15.06.05. A Nurse, RN.

15.06.05 1300 Has commenced exercise classes, finding them difficult because of pain in knees. Encouraged to continue and work at own pace at exercises. Pain lessened slightly with treatment, now 5/10. PLAN: Continue treatment, reassess in 1/52. A Nurse, RN.

22.06.05 1345 Pain now 4/10, exercise classes continued. Reviewed by physio today, exercises modified to reduce pain on movement. Does not feel voltaren gel helpful, treatment ceased. Hot packs helpful after shower and exercise classes to relive discomfort related to movement. Has expressed a wish to try glucosamine. Discussed with GP, to commence tomorrow. Family to supply, resident self-medicating. PLAN: Continue paracetamol as charted. Prompt to take glucosamine with breakfast. Offer hot packs after activity. Reassess in 1/52. A Nurse, RN.

THE RESIDENT'S VERBAL BRIEF PAIN INVENTORY (RVBPI)

Date 12/06/05

Time 1200

Name E. Smith

Date of Birth 06/04/1917

1. Have you had aches, discomfort, soreness or pain today?

☑ YES ☐ NO

2. Please rate your pain by ticking the word that best describes your pain ***right now.***

☐ None ☐ Mild ☑ Moderate ☐ Severe

3. Please rate your pain by ticking the word that best describes your pain ***on movement***.

☐ None ☐ Mild ☐ Moderate ☑ Severe

4. Please rate your pain by ticking the word that best describes your pain ***at its worst over the past 24 hours.***

☐ None ☐ Mild ☐ Moderate ☑ Severe

5. Please rate your pain by ticking the word that best describes your pain ***at its least over the past 24 hours.***

☐ None ☑ Mild ☐ Moderate ☐ Severe

6. Please rate your pain by ticking the word that best describes your pain ***on average over the past 24 hours.***

☐ None ☐ Mild ☑ Moderate ☐ Severe

7. On diagram at right, shade areas where you feel ▶ pain and put an X on the areas that hurt the most.

8. Tick the word that best describes how, during the past 24 hours, pain has interfered with your:

GENERAL ACTIVITY

☐ None ☐ Mild ☑ Moderate ☐ Severe

MOOD

☐ None ☐ Mild ☑ Moderate ☐ Severe

WALKING ABILITY

☐ None ☐ Mild ☐ Moderate ☑ Severe

RELATIONS WITH OTHERS

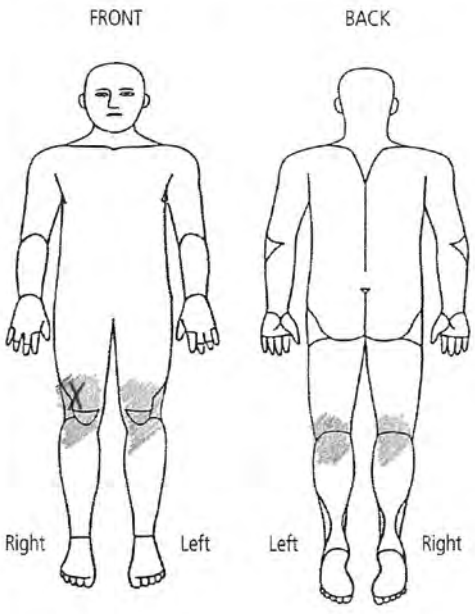
☐ None ☐ Mild ☑ Moderate ☐ Severe

SLEEP

☐ None ☐ Mild ☑ Moderate ☐ Severe

ENJOYMENT OF LIFE

☐ None ☐ Mild ☑ Moderate ☐ Severe



References:

1. Australian Pain Society (2005). *Pain in residential aged care facilities: Management strategies*

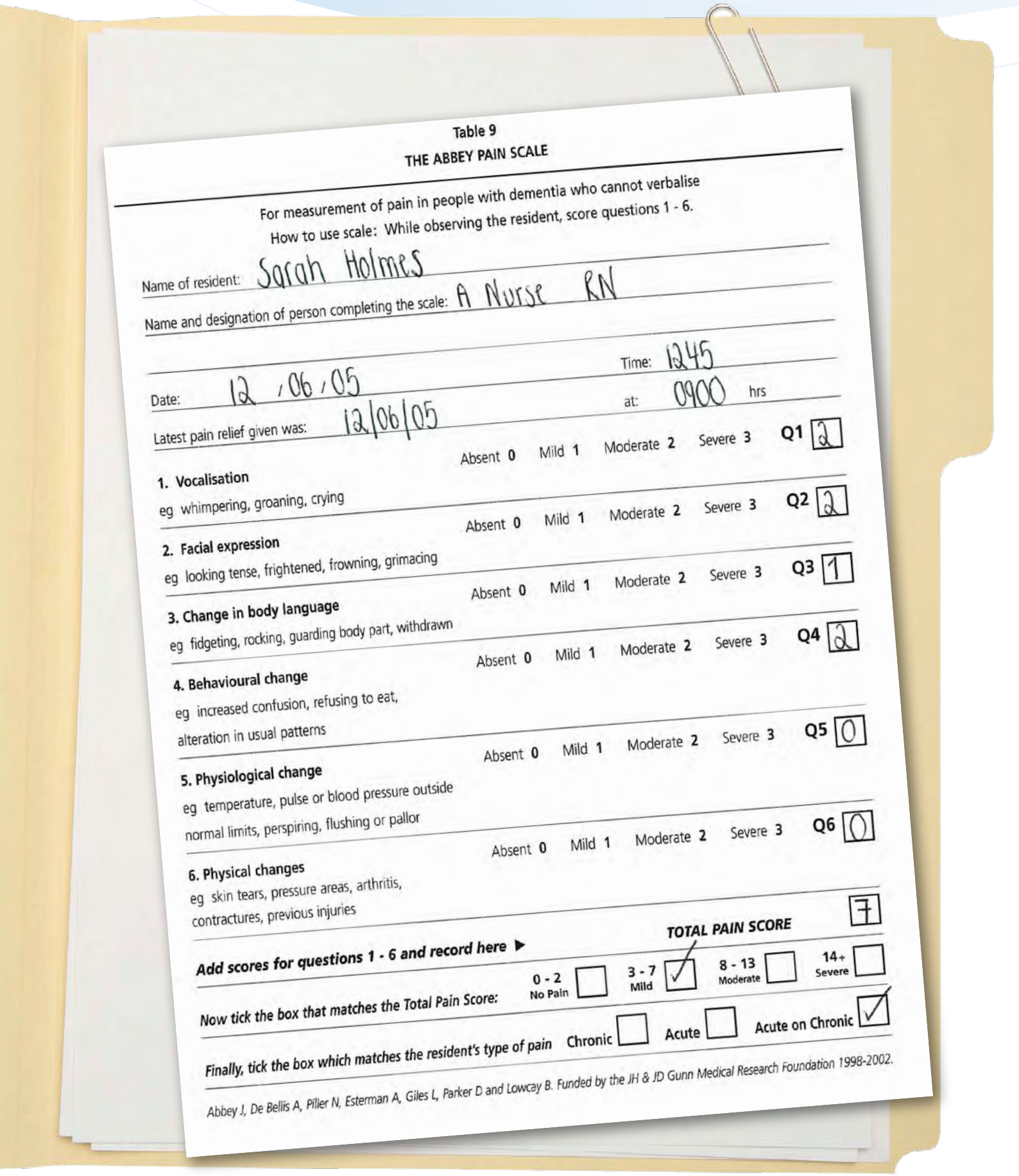


Table 9

THE ABBEY PAIN SCALE

For measurement of pain in people with dementia who cannot verbalise

How to use scale: While observing the resident, score questions 1 - 6.

Name of resident: Sarah Holmes

Name and designation of person completing the scale: A Nurse RN

Date: 12/06/05 Time: 1245

Latest pain relief given was: 12/06/05 at: 0900 hrs

	Absent 0	Mild 1	Moderate 2	Severe 3	
1. Vocalisation eg whimpering, groaning, crying					Q1 2
2. Facial expression eg looking tense, frightened, frowning, grimacing					Q2 2
3. Change in body language eg fidgeting, rocking, guarding body part, withdrawn					Q3 1
4. Behavioural change eg increased confusion, refusing to eat, alteration in usual patterns					Q4 2
5. Physiological change eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor					Q5 0
6. Physical changes eg skin tears, pressure areas, arthritis, contractures, previous injuries					Q6 0

Add scores for questions 1 - 6 and record here ▶ ***TOTAL PAIN SCORE*** 7

Now tick the box that matches the Total Pain Score: 0 - 2 No Pain ☐ 3 - 7 Mild ☑ 8 - 13 Moderate ☐ 14+ Severe ☐

Finally, tick the box which matches the resident's type of pain Chronic ☐ Acute ☐ Acute on Chronic ☑

Abbey J, De Bellis A, Piller N, Esterman A, Giles L, Parker D and Lowcay B. Funded by the JH & JD Gunn Medical Research Foundation 1998-2002.

COMPONENTS & SCORING OF THE PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) SCALE

	0	1	2	Score
Breathing independent of vocalisation	Normal	Occasional, laboured breathing. Short period of hyperventilation. X	Noisy, laboured breathing. Long period of hyperventilation. Cheyne-Stokes respiration*.	1
Negative vocalisation	None	Occasional moan or groan. Low level speech with a negative or disapproving quality. X	Repeated, troubled, calling out. Loud moaning or groaning. Crying.	1
Facial expression	Smiling or inexpressive.	Sad. Frightened. Frowning.	Facial grimacing. X	2
Body language.	Relaxed.	Tense. Distressed pacing. Fidgeting. X	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	1
Consolability	No need to console.	Distracted or reassured by voice or touch.	Unable to console, distract, or reassure. X	2
			TOTAL	7/10

** Cheyne-Stokes respiration is often produced by conditions other than pain.*

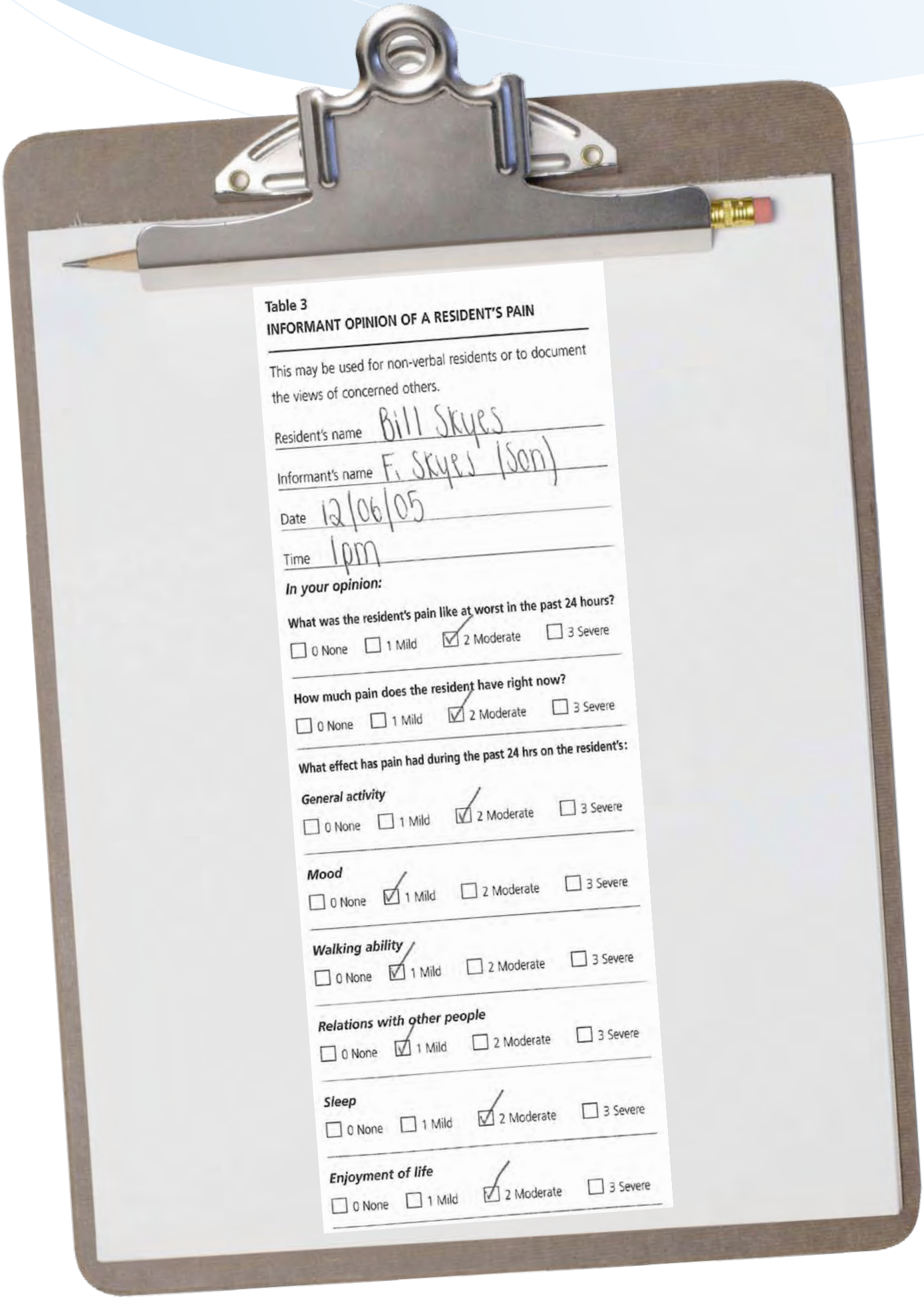


Table 3
INFORMANT OPINION OF A RESIDENT'S PAIN

This may be used for non-verbal residents or to document the views of concerned others.

Resident's name Bill Skyes

Informant's name F. Skyes (Son)

Date 12/06/05

Time 1pm

In your opinion:

What was the resident's pain like at worst in the past 24 hours?

☐ 0 None ☐ 1 Mild ☑ 2 Moderate ☐ 3 Severe

How much pain does the resident have right now?

☐ 0 None ☐ 1 Mild ☑ 2 Moderate ☐ 3 Severe

What effect has pain had during the past 24 hrs on the resident's:

General activity

☐ 0 None ☐ 1 Mild ☑ 2 Moderate ☐ 3 Severe

Mood

☐ 0 None ☑ 1 Mild ☐ 2 Moderate ☐ 3 Severe

Walking ability

☐ 0 None ☑ 1 Mild ☐ 2 Moderate ☐ 3 Severe

Relations with other people

☐ 0 None ☑ 1 Mild ☐ 2 Moderate ☐ 3 Severe

Sleep

☐ 0 None ☐ 1 Mild ☑ 2 Moderate ☐ 3 Severe

Enjoyment of life

☐ 0 None ☐ 1 Mild ☑ 2 Moderate ☐ 3 Severe

Sample Pain Chart

Please observe resident and document any time pain is recognised, or at least every shift

Date/ Time	Pain Location	Pain Score	Activities/behaviours related to pain	Treatment given	Results of treatment
12.06.05 1200	R) Knee	7/10	Walking, transferring	Commenced paracetamol Hot pack on knee	Assess 1400
12.06.05 1400	R) Knee	6/10	Currently resting	Paracetamol 1200	Pain score slightly decreased. Still periencing difficulties with transferring.
12.06.05 2100	R) Knee	7/10	RIB all shift, refused to walk to dining room for dinner.	Paracetamol 1800 Hot pack x 2 Voltaren gel x 1	Remains unwilling to transfer, knee still swollen.
13.06.05 0700	R) Knee	5/10	Slept overnight. Some discomfort when transferring onto commode this morning	Paracetamol 2200 and 0600	Unable to assess
13.06.05 0930	R) Knee	7/10	Showering, transferring	Warm shower Voltaren rub Hot packs at completion movement	Pain with movement continues
13.06.05 1130	R) Knee	8/10	Exercise class	Hot pack on completion	Hot pack gave some relief
13.06.05 1900	R) Knee	6/10	RIB most shift. Dinner in room.	Paracetamol 1 Hot pack x 2	States comfortable at rest. Unwilling to move too much after exercise class this morning

Prepared by Edith Cowan University
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