Edmonton Zone Continuing Care Interdisciplinary Pain Assessment & Management Guideline

June 2015
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Continuing Care Interdisciplinary Pain Assessment & Management Guideline

INTRODUCTION

In February 2014 the Registered Nursing Association of Ontario released the third edition of Assessing and Managing Pain. In light of these most recent evidenced based guidelines work on updating the 2005 Edmonton AHS Pain Standard was begun. The following Guideline is in alignment with the RNO principles.


Pain assessment and management is part of the expectation for Best Practice with regard to Resident Care and is reflected in both Accreditation Standards for Long Term Care (2005) and Alberta’s Continuing Care Health Service Standards (2010).

PURPOSE OF THE GUIDELINE

To promote consistent interdisciplinary team evidence informed practice for continuing care residents in the recognition, assessment and management of pain.

Goals
- To encourage baseline screening, assessment and monitoring parameters for pain.
- To assist in the development of individualized interdisciplinary treatment plans for pain management
- To assist in the regular evaluation and modification of individualized interdisciplinary treatment plans for pain management

PRINCIPLES OF PAIN ASSESSMENT & MANAGEMENT

Pain is a subjective, multidimensional and highly variable experience.
- Any pain that has an impact on physical function, psychosocial function, or other aspects of quality of life is recognized as a significant problem.
- The most accurate and reliable evidence of the existence of pain and its intensity is the resident’s report.
- Residents have the right to the best pain management possible.
- For some pain conditions it may not be possible to achieve complete absence of pain and reduction may be all that is possible
- Effective pain management requires an interprofessional team approach.
- Pain management decisions are person centered therefore made in collaboration with the resident and family.
- Clinical competency in pain assessment and management as part of scope of practice is relational to ongoing staff education and development.

ORGANIZATIONAL PAIN ASSESSMENT & MANAGEMENT PROGRAMS

Structural and Process Program Indicators:
- Evidence of Edmonton Zone Facility Living Pain Assessment and Management Guideline (2014) implementation including the Continuing Care Pain Assessment Tool (Appendix A) or other evidence based Pain Guidelines with related assessment tools.
- Evidence of an organizational interdisciplinary team approach to resident pain assessment and management.
- Evidence of interdisciplinary staff educational opportunities including evidence-based strategies to assess, minimize, or relieve pain.
- Utilization of zone based available resources, such as the Regional Palliative Care team and chronic pain specialists.
- Individualized person centered resident care plans reflective of resident and family expectations and values as well as goals, interventions, monitoring parameters and evaluation regarding pain.
- Additional Program Indicators: Provision of interdisciplinary based education to residents and families regarding pain assessment and management interventions.

Program Outcome Indicators:
- Pain scores from resident screening for pain during the InterRAI MDS 2.0 Assessment on admission, quarterly and with a change in the health status.
- Further assessments with the Continuing Care Pain Assessment Tool or other evidence based pain related assessment tools for residents with a MDS 2.0 Outcome Scale pain score greater than 1, and similar ‘just in time’ assessments for clinical indications.
- Resident specific interdisciplinary care plans for pain management including comfort goals, interventions, clinical monitoring and evaluation parameters are in place.
- Documentation of the results of pain management strategies, including the adverse effects and effectiveness of pain interventions.
- Monitoring and interventions related to the InterRAI Quality Indicators PA10X (Percent of Resident with pain) and PAN01 (Percent of residents whose pain worsened)

SCREENING FOR PAIN

In Facility Living nursing staff, including health care aides, have the most contact with a resident receiving health care and as such must play an important role in screening for pain. Staff interventions include but are not limited to the following:

- The resident is questioned directly and, observed daily for the presence of pain, aches, hurts or discomfort. Indications of pain are reported, treated, and documented as soon as possible according to facility policy.
- Attention to the presence of markers for nonverbal residents, or residents with dementia such as:
  - crying/moaning;
  - changes in behaviour, activity patterns, routines and functioning status:
  - as well as, awareness of the presence of diagnosis which indicate chronic painful disease conditions
- Sensitivity to resident comfort prior to, during, and after a procedure particularly if the procedure if known to cause pain. Examples would include but not be limited to wound care, treatment delivery which breaks the skin barrier, and interventions such as surgery or drainage tube insertion or removal.
- Completion of the RAI MDS 2.0 assessments in accordance with CIHI (Canadian Institute for Health Information) and ACCIS (Alberta Continuing Care Information System) guidelines
ASSESSING FOR PAIN

The Continuing Care Pain Assessment Tool (2013) or another evidence based assessment tool will be utilized to assess pain in all residents who have been screened as or identified as having pain.

Additional suggestions:
- a physical examination and relevant laboratory and diagnostic tests be completed
- a comprehensive medication review be completed and documented

Reassessment of the resident with the Continuing Care Pain Assessment tool (2013) or another evidence based assessment tool is advised within 72 hours, or sooner, of initiating or changing pain medication.

**Cognitively Well Residents**
In the event of positive resident screening for pain or identified pain, residents who are able to self identify pain should undergo a comprehensive pain evaluation, to identify all potentially remediable factors. The comprehensive review should focus on identifying a sequence of events that led to the present pain complaint, on establishing a diagnosis and on developing a resident specific interdisciplinary treatment plan.

The following parameters should be considered:
- the resident’s attitudes / beliefs regarding pain and its management,
- the resident’s knowledge of pain management strategies,
- resident’s preferences and response to receiving information related to his/her condition and pain,
- the resident’s coping responses to stress and pain,
- effects of the identified pain on the resident’s activities of daily living,
- psychosocial and spiritual effects of the identified pain on the resident,
- Cognitive function status changes: should be evaluated for new or worsening confusion,
- situational factors: culture, language, ethnic factors, family support, economic effects of pain and treatment.

Self-report is the primary source of assessment for cognitively well residents. Assessment will include the use of a pain intensity (verbal or numerical) rating scale (Appendix A).

**Non-verbal residents or residents with severe dementia**
Pain Assessment for a non verbal resident or residents affected by advanced dementia will include the use of the behaviour observation tool (PAINAD). Assessment of pain in residents with early to moderate dementia should be attempted with self report scales and in the event of poor success with either the verbal or numeric scale the PAINAD scale may be used.

A new behaviour or a change in behaviour in a resident with limited ability to communicate verbally should trigger a pain assessment.

As part of the pain evaluation, rule out constipation as a contributing factor, consider delirium and/or depression as causal factors and treat accordingly.

**Self-Report Scales**
Pain is a multidimensional subjective experience so self-report is the most valid way of assessing pain (RNO Best Practice Guidelines 2014). Pain assessment tools may be either one dimensional (looking only at one aspect of pain such as intensity) or multidimensional when a more comprehensive pain assessment is warranted. The Revised Continuing Care Pain Assessment Tool (2013) contains two uni-dimensional recognized and validated tools for quantifying pain intensity as some residents find it easier to use a numerical and some a verbal scale. In the initial assessment, residents should be asked to use both scales, and asked which scale they find easiest to use. The resident’s preferred scale should be documented, and used for all subsequent pain assessments and monitoring of resident
response post interventions. The instructions for use should be repeated each time the scale is used unless the resident indicates they already know them.

**Observation Scale**

Persons with verbal communication deficits such as those in dementia may not be able to talk about their pain. Residents with mild to moderate dementia may be able to self-report their pain; however, if they are unable to self-report an observation scale should be used. The Revised Continuing Care Pain Assessment Tool (2013) contains a third validated scale predicated on observation. PAINAD is to be used when the resident is unable to use a self-report scale. It is different from a self-report scale as it **does not measure the intensity of the pain**, but can be used to determine if the resident is experiencing pain and to evaluate attempts to relieve the pain.

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**CLINICAL MONITORING OF PAIN**

Clinical monitoring of pain in residents in continuing care includes but is not limited to:

- observation of the resident at rest and during activities of daily living
- use of one or more pain scales to determine the presence of pain, intensity of pain, effectiveness of pain interventions and in some cases the ability of the resident to manage his or her pain
- analgesic review including prn frequency and effectiveness as well as monitoring for signs and symptoms of opioid toxicity
- psychotherapeutic medications review including frequency and effectiveness

Pain is reassessed and documented after an intervention is provided. The timing and frequency of the monitoring will be individualized and dependent upon the intervention.

Reassessment should:

- Use the same pain scale which the resident found the easiest to complete in the initial comprehensive assessment
- Include evaluation of analgesic and non-pharmacologic interventions, adverse effects, and compliance issues.

Further assessment is required if pain is unrelieved or an intervention is unsuccessful.

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**DOCUMENTATION OF PAIN**

- Suggested documentation for pain assessment(s) on the Edmonton Zone Facility Living Revised Continuing Care Pain Assessment Tool (2013) Appendix A.
- Document pain scale utilized and interventions. Suggested documentation is on the Edmonton Zone Facility Living Revised Continuing Care Pain Management Flow Chart (Appendix B).
- Care Plan documentation regarding pain shall include: preferred pain scale, resident specific language and or behaviors attributed to pain, targeted outcome score for pain, resident and interdisciplinary goals and interventions to manage pain
- Interdisciplinary progress note documentation shall include:
  - Type and efficacy of interventions delivered not documented on the pain flow sheet and/or care plan as well as any adverse effects, and resident stated responses.

**Interdisciplinary Care Planning**

Residents and families will be included by the interdisciplinary team in the development and changes to the treatment plan for pain management.
PAIN MANAGEMENT

- Consider the least invasive strategies/treatments as well as strategies and treatments that have the least number of side effects first in the treatment and development of the plan of care.
- Therapy should be individualized, balancing benefits and risks.
- Residents whose pain is not relieved after following standard principles of pain management require referral for a consultation with a specialist or service with expertise in pain management (e.g. clinical nurse specialist, Regional Palliative Program).

Non-pharmacological Interventions
The interdisciplinary team may consider the use of non-pharmacological interventions along with pharmacological interventions but not as a substitute (RNO 2014). The following are non exclusive examples which could be considered in an individualized treatment plan;
- Massage
- Socialization/activation activities
- Pastoral care interventions
- Social work sessions
- Music therapy
- Pet therapy
- Rehabilitation: splinting, Transcutaneous Electrical Nerve Stimulation (TENS), ultrasound, manual therapy, exercises, acupuncture, acupressure, heat and cold modalities, sensory stimulation, and relaxation

Pharmacological Interventions
A multimodal analgesic approach utilizing pharmacologic interventions such as non-opioid and opioid medications and adjuvant medications is supported by clinical research (RNO 2014)

To achieve the most efficacious outcomes with multimodal approach nurses should adhere to the following principles:
- Use the most effective least invasive way to administer analgesics
- Use non-opioids to manage mild to moderate pain
- Use opioids in combination with non-opioids to manage moderate to severe pain
- Use advanced modalities to manage persistent non-malignant or cancer pain and acute pain
- Advocate for the most effective dosing schedule considering the medication duration on onset and half-life
- Recognize potential contraindication such as co-morbidities or drug to drug interaction related to the clinical condition
- Titrate pain medication to achieve maximum effectiveness while minimizing adverse effects
- Anticipate and manage adverse effects from pharmacologic interventions
- Consider consulting the interprofessional team or pain-management experts for complex pain situations

Adapted from: Registered Nurses Association of Ontario. (2014). p. 33-34;

Non opioid Medications
- Older adults are at higher risk for adverse Nonsteroidal Anti Inflammatory Drug (NSAID) effects: most significantly Congestive Heart Failure (CHF) and gastrointestinal ulceration and bleeding
- The decision to manage persistent pain with NSAID requires individualized consideration of factors such as co morbidities, concomitant medications and associated risk factors

Opioid Medications
- Opioid medications should be prescribed on a trial basis with clear therapeutic goals and the understanding the opioid will be discontinued if the trial is unsuccessful
- The health care team should anticipate and monitor persons taking opioids for common adverse effects such as nausea, vomiting, constipation and drowsiness
- Regular systematic sedation and respiratory assessments are recommend to evaluate a person’s
response during opioid therapy

Adjuvant Medications
- Adjuvant drugs such as antidepressants, anticonvulsants, muscle relaxants, and topical preparations can assist in the management of pain.
- Older adults may be more susceptible to the anticholinergic, cardiovascular and CNS effects of tricyclic antidepressants. Treatment should begin with lower initial dosages and more gradual increases are warranted. (RxMed: http://www.rxmed.com/b.main/b2.pharmaceutical/b2.1.monographs/CPS-%20Monographs/CPS-%20(General%20Monographs-%20A)/AMITRIPTYLINE.html)

Further Considerations
- Older persons with functional impairment or decreased quality of life are candidates for pharmacological therapy with careful weighing of risks and benefits.
- Positive outcomes are maximized when clinicians monitor residents for adverse effects.
- Analgesic dosing in older adults requires careful titration because age-adjusted dosing is not readily available.
- It is unrealistic for some persistent pain conditions to expect complete absence of pain.
- Rapid-onset short acting analgesics should be used for severe episodic pain.
- Scheduled administration before anticipated pain incidents is recommended for residents who are unable to communicate their needs; i.e. residents with dementia.
- Continuous pain medications should be provided around the clock with faster short acting analgesics ordered for breakthrough pain.
CONTINUING CARE
PAIN ASSESSMENT TOOL

Date: ______________________  Time: _____________  Assessor: _________________________

Complete the information below to identify current care concerns specific to the resident’s pain. The resident may use the word “pain” or may use other terms such as ‘ache’, ‘hurt’, ‘discomfort’, or ‘sick’. Document the term the resident uses to describe his/her pain on the pain management flow record (Side B) and on the care plan.

1. Ask the resident to indicate where he/she has pain. Mark the pain location(s) on the diagram.

If there is more than one site or pain type; Ask the resident “Which pain is bothering you the most? Document what they tell you.

2. Quality (Ask the resident to describe the pain. If the resident is unable to self-report, proceed to Question 3):

   - Aching
   - Throbbing
   - Tingling
   - Tiring
   - Other (use resident’s words):

   - Burning
   - Sharp
   - Numb
   - Exhausting
   - Nagging
   - Tender
   - Stretching
   - Unbearable
   - Pulling
   - Shooting
   - Hammering
   - Radiating

3. Intensity: Pain Intensity Scales

   Show the resident the pain intensity scales. Ask the resident to rate his/her pain using both the numerical and verbal scales. Assess which scale was most meaningful to him/her and the most useful for self report. If unable to use self report scales - assess using PAINAD.
Document Resident preferred scale:  Numeric ☐  Verbal ☐  PAINAD ☐

This is the scale which will be used to monitor the resident’s pain and the effects of the interventions.

4. Frequency: How often do you have the pain?
   ☐ Constant  ☐ Intermittent (specify frequency and duration)

   Comments: ____________________________________________

5. What makes the pain worse?

   Comments: ____________________________________________

6. What makes the pain better?
   ☐ Heat  ☐ Cold  ☐ Massage  ☐ Relaxation
   ☐ Medications (Name)
   ☐ Topical preparation(s)
   ☐ Other (TENS, physio, acupuncture, doing something else, lying still):

   Comments: ____________________________________________

7. Does pain interfere with sleep and rest?  ☐ Yes  ☐ No
   If yes:
   ▪ Do you have problems getting to sleep because of the pain?  ☐ Yes  ☐ No
   ▪ Does the pain wake you up during the night?  ☐ Yes  ☐ No
   ▪ What do you do?
   ▪ Do you wake up with pain in the morning?  ☐ Yes  ☐ No

8. Does the pain interfere with activities of daily living:  ☐ Yes  ☐ No
   Does the pain interfere with your ability to move (include dressing, transfers, and mobility)?  ☐ Yes  ☐ No
   Does the pain affect your appetite?  ☐ Yes  ☐ No  ☐ Increase  ☐ Decrease
   Do you have pain when you have a bowel movement?  ☐ Yes  ☐ No
   Do you have pain when you pass your urine?  ☐ Yes  ☐ No
   Does the pain affect your mood?  ☐ Yes  ☐ No

   Comments: ____________________________________________


10. Indicate which of the following may predispose the resident to have pain:

    ☐ Immobility  ☐ Haemorrhoids  ☐ Other:
    ☐ Arthritis  ☐ Past amputations
    ☐ Cancer  ☐ Peripheral Vascular Disease
    ☐ Angina  ☐ Fracture(s) including compression #
    ☐ Contractures  ☐ Surgery
    ☐ UTI  ☐ Wounds

    Identify the care concerns and determine goals; add them to the care plan and determine interventions to address each of the concerns. Specify the pain intensity scale to be used for reassessment in the care plan.
Use the appropriate pain scale to assess and measure the resident’s pain.

NOTE: The self-report scales (Verbal or Numeric) and PAINAD are different. Scores from the scales cannot be compared.

1. Pain Intensity Scales
   A. Numeric Rating Scale (NRS) Identify the number that best describes your pain:
      
      Worst Possible Pain 10
      9
      8
      7
      6
      5
      4
      3
      2
      1
      No Pain 0

      Flaherty. (2000).

   B. Verbal Rating Scale Identify the word that describes your pain:
      
      Excruciating
      Horrible
      Distressing
      Discomforting
      Mild
      No Pain


2. PainAD (for residents who are non-verbal)

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<th>ITEMS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>SCORE</th>
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<tr>
<td>Independent of vocalization</td>
<td></td>
<td></td>
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<tr>
<td>Negative Vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low level speech with a negative or disapproving quality.</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying.</td>
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<td>Consolability</td>
<td>No need to console.</td>
<td>Distracted or reassured by voice or touch.</td>
<td>Unable to console, distract, or reassure.</td>
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   Directions:
   (1) Observe resident for 5 minutes;
   (2) Score each item out of 2;
   (3) Add total score;
   (4) Observe for subtle behaviors not picked up by PAINAD;
   (5) Document and report.

   Warden (2003)
Please use the appropriate pain rating scale from Side A

- Pain Rating Scale used:  Verbal  Numeric  PAINAD

Identify the resident's word(s) used to describe pain: ___________________________

Indicate the pain site(s); identify the most intense pain site with an *

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<tr>
<th>DATE (dd/mo/yr)</th>
<th>TIME</th>
<th>PAIN SCALE RESULT</th>
<th>SITE/COMMENTS/OBSERVATIONS</th>
<th>Initials</th>
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Developed by AHS/Edmonton Zone/Seniors Health/Integrated Facility Living/2010_02Feb
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Additional Relevant Literature

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