



Pain Assessment and Management

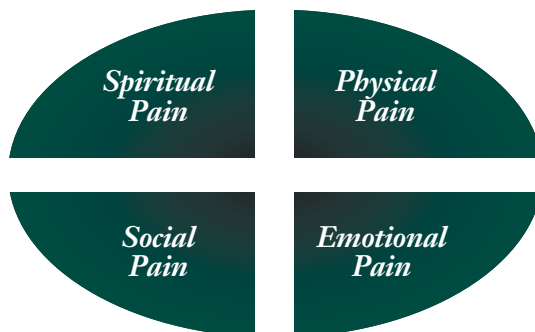
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What is pain and why is it so important?

It is estimated that approximately 2 million Americans live in nursing homes and up to 80% of all long term care patients experience substantial pain. (Won, LaPane, Vallow, Schein, Morris, et al., 2004). It is thought that this high prevalence of unrelieved pain may result from under recognition which may result in under-treatment. When pain is not recognized and not correctly treated, there can be serious consequences for the quality of life for our patients.

What is pain?

As we begin to understand what pain is, it is important to understand that pain is more



than just physical. Nurses and doctors are primarily focused on the physical aspects of pain and often medications are the solution. We need to understand that people experience many different types of pain that often influence the physical aspects of pain. When patients have social, emotional and spiritual concerns (family losses, financial concerns, broken relationships, serious medical conditions and spiritual issues, why me?), they often express this pain in a physical manner. Patients develop neck and shoulder pains, headaches and back pain. This pain is “real” and may need to be managed with

expert help from trained social workers, counselors and chaplains. It is vital that patients in pain are approached from a coordinated multidisciplinary approach.

Definition of Pain

In 1968, Margo McCaffery defined pain as “whatever the experiencing person says it is, existing whenever the experiencing persons says it does.” This definition focuses the caregiver to listen to and believe the patient’s report of pain. Our first professional responsibility to the patient in pain is to acknowledge and believe the patient’s report. Pain is subjective and requires us to put aside our own opinions and believe the patient’s report.

Bill of Rights

The Bill of Rights for patients in pain provides a foundation for appropriate pain assessment and management of pain. These five “rights” are described below:

Patients have a right to have their pain believed. It is important that caregivers demonstrate to the patient that we acknowledge and believe his/her report of pain, which is reflected in our body and spoken language.

Patients have a right to have their pain assessed and managed promptly.

As caregivers, we need to respond in a timely manner to our patient’s requests. It is not appropriate for a patient to wait long periods of time to receive pain medications.

Patients have a right to be treated with respect at all times.

We have a responsibility to “do the right thing” and not disrespect our patients with our attitudes, body or spoken language.

Patients have a right to have their pain anticipated and managed.

As clinicians we need to understand that procedures such as bathing, ambulation,

transfers and dressing changes may cause pain, and patients may need to receive pain medication prior to these procedures to diminish or eliminate pain. It is essential that we plan for these events and appropriately manage this “incident pain.”

Patients have a right to participate in their pain management.

Patients and families have a right to understand about the proposed plan of care and need to participate in the planning of that care. Belief and participation in the plan will always produce more positive results.

Unrecognized Pain

Sometimes, we expect a patient in pain to act in a particular way. As healthcare providers, we have been taught to look for indicators for pain such as grimacing, moaning and groaning. Many of our older patients may develop impaired cognition, and the demonstration of pain may look somewhat different. We need to consider behaviors such as aggression, biting, hitting, resisting care, yelling, and fighting as possible and potential indicators of pain. Patients may not always act as we think they should. In older patients who are cognitively impaired, we will need to first consider their diagnoses as possible indicators for pain.

Un-Relieved Pain

It is important to treat the right type of pain with the right medication. When we don't interpret each type of pain that the patient may be experiencing, we often have the potential to only manage one type of pain and may miss another type of pain. This may lead to poor pain management and result in increasing medications that may not be necessary. Very often our older patients experience combinations of pain and require multiple or combinations of medications.

Under-treated Pain

Sometimes pain is not appropriately treated because of concerns about dosages of medications. It is always appropriate to treat patients with the smallest number of medications and the least dosage possible. Often when patients have chronic pain issues and have been on medications for long periods of time, they will develop a tolerance to either the medication or the dose. When patients continue to need larger doses of medication to appropriately treat their pain, this is often misinterpreted and the patient may be under-treated.

Myths of Pain and its management:

1. Lack of physical evidence

Many healthcare providers would prefer a “laboratory test” or some tangible evidence that a patient “really” has pain.

Clearly the cause of pain cannot always be determined but not finding the cause should not lead us to ignore or deny the patient's report of pain. Pain is subjective and needs to be acknowledged by the healthcare provider.

2. Concern that analgesia will mask diagnostic information

The American Pain Society (1992) states that *“In cases in which the cause of acute pain is uncertain, establishing a diagnosis is a priority, but symptomatic treatment of pain should be given while the investigation is proceeding.”* Pain should no longer be the clinician's primary diagnostic tool.

3. Belief that non-cancer pain is not as painful as cancer pain

Studies have indicated that inadequate pain management is more likely when pain is NOT attributed to cancer. There is often a disregard of pain in patients that have



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“chronic” pain issues, i.e. arthritis and back pain. One way to address this issue may be to ask, “*why are we more willing to treat a dying patient in pain than a patient who may have many more years to live – in pain?*”

4. Implication that anxiety or depression is the cause

When the cause of pain is unknown or the degree of pain seems inappropriate, healthcare providers often attribute the pain to the patient's emotional state and not appropriately treat the pain. Sometimes statements as “the pain is all in his/her head” are made which can lead to inadequate pain management. Often, anxiety and depression are a result of a patient not receiving appropriate and adequate pain assessment and management.

What is Addiction?

Several studies have indicated that “addiction” as a result of using opioids for pain relief occurs in less than 1% of

patients. The disease of addiction is complex, multicausal and occurs over time. Opioid addiction is a psychological dependence. It is a “*pattern of compulsive drug use characterized by continued craving for an opioid and the need to use the opioid for effects other than pain relief.*” (American Pain Society, 1992) Addiction usually has three features, loss of control over drug use, compulsive drug use and continued use despite harm.

If a patient takes pain medication for pain management, this is NOT addiction, regardless of dose or length of time.

What is Pseudoaddiction?

This condition is a pattern of “drug seeking behaviors” in pain patients that are receiving inadequate pain management. Behaviors indicative of uncontrolled pain or fear of uncontrolled pain are often misinterpreted as addiction. These behaviors may include, “clock-watching,” demanding behavior and manipulation.

What is Physical Dependence?

This is a physiologic phenomenon that manifests as the development of withdrawal symptoms after an abrupt discontinuation of opioids. Physical dependence indicates neither the presence nor absence of addiction. When opioids are significantly reduced or withdrawn they should be slowly weaned.

What is Tolerance?

Tolerance is a predictable physiologic response characterized by the decreasing effects of a drug and the subsequent need for a higher dose or a change in medication to maintain the effect. This should not be confused with addiction. Patients and families often need to be educated about this phenomenon to ensure compliance with medication regimens.

Consequences of Un-assessed and Un-managed pain

Physical Consequences:

When patients are not adequately assessed or managed for their pain, they often suffer physical consequences that may include:

- Decreased activity
- Increased fatigue
- Increased falls
- Poor appetite – weight loss
- Nausea
- Altered sleep patterns
- Altered immune system – more susceptible to infections

Psychological Consequences

- Anxiety
- Depression
- Anger/agitation
- Fear
- Poor compliance

Social Consequences

- Diminished social relationships
- Financial concerns
- Issues with sexuality

Spiritual Consequences

- Purpose-why me?
- Religious challenge
- Increased emotional suffering

Metabolic Consequences

- Increased ACTH, cortisol, ADH, epinephrine levels
- Hypercoagulation
- Increase myocardial oxygen consumption
- Atelectasis
- Fluid overload
- Decreased GI motility

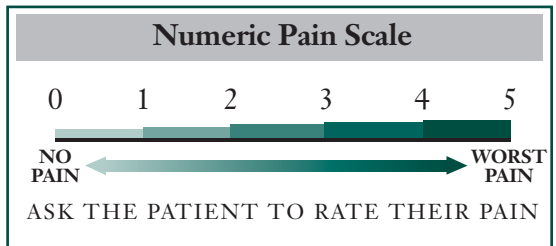
All of these consequences from un-assessed and un-managed pain can significantly add to the gravity of an already medically compromised patient.

Pain Assessment Scales

To assist the staff in the pain management process, sets of laminated cards with assessment tools are available. These assessment tools include numeric scale, color scale, faces scale, non-cognitive scale, descriptive words for pain, common pain diagnoses, and suggestions for pain management. These tools are to assist the patient in participating in his/her pain assessment and management.

It is important to use the same scale for all assessments in any particular patient.

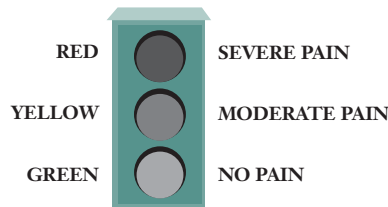
Listening carefully to the patient and believing his/her report of pain will provide the most accurate assessment of his/her pain. The various pain scales should be explained to the patient, and the patient should be assisted in choosing a scale that he/she is comfortable utilizing. The patient's subjective report is the most accurate assessment of pain.



Descriptor Scale



Color scale



Faces Scale





Non-cognitive scale

This scale should be utilized only when the patient is unable to report his/her own pain level. The ability to report pain may be compromised due to impaired cognitive function. This may be seen in various forms of dementia and Alzheimer’s disease.

Administration Record). This documentation should include the numeric rating of the pain either subjectively (the patient’s report) or objectively (the nurse assessment-using the non-cognitive scale) and the nurse’s initials.

In addition to asking about the intensity of pain, it is important to also assess for the

	0	0.5	1.0	Score
Breathing	Normal	Occ. labored hyperventilation	Noisy labored Hyperventilation Cheyne-Stokes	
Negative Vocalization	None	Occ. moan or groan. Low level speech with negative quality	Repeated troubled calling out, loud moaning or groaning, crying	
Facial Expression	Smiling or inexpressive	Sad, frightened Frowning	Facial grimacing	
Body Language	Relaxed	Tense, rocking, distressed pacing, guarding, fidgeting, rubbing, irritable	Rigid, biting, fists clenched, pulling/pushing away, striking out	
Consolability	No need to console	Distracted or reassured by touch	Unable to console, distract or reassure	
Total				

At least once each shift, the nursing staff is required to ask the patient if he/she is having any pain. Remember that a patient may have a different interpretation of words, so it is important that a variety of words be used to ask about pain. An example might be to ask if the patient is hurting, or sore, or uncomfortable or aching instead of just using the word “pain.”

The shift pain assessment should be documented in the MAR (Medication

quality of the pain. Descriptive words that may be presented to the patient might be:

- Aching
- Deep
- Cramping
- Sharp
- Stabbing
- Shooting
- Pressure
- Throbbing
- Squeezing
- Dull
- Tingling
- Burning
- Radiating

References

McCaffery M, Pasero C, Pain Clinical Manual 2nd Edition. St. Louis. Mo Mosby 1999

JCAHO Comprehensive Accreditation Manual for Home Care/Hospice 2004-2005

Won A, LaPane K, Vallow S, Schein J, Morris J., Persistent Nonmalignant Pain and Analgesic Prescribing Patterns in Elderly Nursing Home Residents. J Am Geri Soc. 2004.

Signs of Approaching Death

Each death will be as unique as each patient. When you spend time with hospice patients, you may recognize some of these signs or see a pattern of change:

- never assume you know what stage the patient is in
- never share your thoughts about stages with the family or caregiver.

If you have questions or concerns, talk with your Volunteer Coordinator.

Remember, you are not clinically trained

Frequently Asked Hospice Questions

What symptoms can I expect?

Changes in body temperature, skin color, breathing patterns, level of consciousness with confusion, difficulty in swallowing.

Will all of these occur at the same time?

No. Not all of these symptoms will appear at the same time, and some may never appear.

Patient seems so restless. Does this mean there is new pain?

Probably not. Restlessness or picking at bed linen usually reflects a decrease in oxygen circulation to the brain and a change in metabolism.

How will family/caregiver manage if he can't control his bowel or bladder?

Incontinence (loss of control) is usually not a problem until death is imminent. There may be a significant decrease in the amount of urine and stool produced. The sphincter muscles will start to relax, and the patient will be less aware of the feeling of elimination.

What does the "rattle" mean?

Secretions in the throat may become more profuse, but the patient's weakness prevents coughing effectively. This noise is distressing to hear but does not indicate pain. Elevating the head of the bed and providing increased humidity will make breathing easier. Positioning the patient on his or her side may help lessen the rattle.

Sometimes the breathing just stops for a while. Is this a final sign?

You may notice an irregular breathing pattern while the patient sleeps. There may be a 10 - 30 second lapse between breaths (apnea which is common and indicates a decrease in circulation and a build-up of waste products. It may last for days or even weeks.

Does the confusion come from the drugs?

Confusion and disorientation reflect a slowing of the neurological system. Allow the patient to verbalize; do not correct or argue with his or her perception.

How would I know if death has occurred?

Signs of death include: no breathing, no heartbeat, incontinence (loss of bowel or bladder control), eyelids slightly open with eyes fixed, and jaws relaxed and slightly open.

What should I do?

Contact your United Hospice office and Volunteer Coordinator immediately.



Emotional & Physical Changes in a Hospice Patient

Withdrawal from:

- Social activities
- Family members or neighbors or church friends
- Favorite hobbies, reading, or television programs

Changes in sleeping and eating patterns

- Decreased food interest
- Loss of appetite; taking liquids less often
- Increased sleeping
- Less communication and conversation

Physical Body Changes Of a Dying Patient

- Decreased body temperature
- Changed blood pressure, up or down
- Blotchy, purplish or bluish skin color
- Irregularity in breathing patterns; congestion
- Decreased level of consciousness and/or responsiveness
- Inability to swallow
- Restlessness or semi-consciousness
- Inability to respond: hearing and/or visual
- Urinary and bowel changes

Summary

- Withdrawal from people; may not want visitors
- Decreased food and fluid intake; not interested in eating or drinking
- Increased sleeping
- Decreased communication
- Disorientation; agitation; confusion
- Decreased blood pressure
- Respiration and breathing irregularities
- Increased congestion
- Fluctuation of temperature
- Fluctuation of energy levels
- Mottling of skin...blue, purplish color of skin, blotchy
- Decreased urine and/or stools
- Restlessness or no activity
- Weakened pulse

Suggestions for Comfort Measures

Use warm, light-weight blankets (not electric), ask if the patient is cold and would like something added to the bed or chair.

Remind patient frequently of the day, the time, and who is in the room and who is speaking; always remind patient of who you are.

Keep lights on in the room as vision decreases; always assume that the patient hears and understands everything said.

Touch the person as you speak because it helps him/her orient towards you, and it offers emotional security that you are present; remember to ask permission before touching.

Speak calmly with a soothing voice to a confused person; remember, some senses become more acute for some patients.

Touch or move the body very carefully because discolored skin is fragile; always ask permission first.

Offer ice chips, sips through a straw or a cool moist cloth to relieve dehydration; the patient may not want food or fluids; always ask patient what he/she prefers.

Honor the patient's requests and needs.

