POLICY & PROCEDURE NUMBER:
DEPARTMENT: *Nursing* **SUBJECT:** *Pain Management*

APPROVAL DATE: April 2004 **REVISION DATE: Oct. 2019; March 2023**
REVIEW DATE: Dec. 2020; **March 2022**

PURPOSE:

The purpose of the Pain Management Program is to maintain an interdisciplinary team approach to pain management that provides the resident with optimal comfort, dignity and quality of life.

The program focuses on:

- communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired
- strategies to manage pain including non-pharmacologic interventions, equipment, supplies, devices and assistive aids, and comfort care measures
- monitoring of residents' responses to and the effectiveness of the pain management strategies.

The program ensures team training, communication and effective care planning.

OBJECTIVES:

- To improve and maintain a resident's optimal functional level and quality of life.
- To optimally control pain for all residents.
- To reduce incidence of unmanaged pain.
- To ensure best practice interventions for residents with pain.
- To monitor and track trends related to pain management.

POLICY:

Each resident must have a formal pain assessment on admission and be reassessed on readmission, quarterly and at significant condition changes. Residents experiencing pain must be treated using non-pharmacological and pharmacological methods to optimally control pain, maximize function and promote quality of life.

RAI-MDS 2.0 assessment protocols and outputs will be reviewed in relation to pain and pain control with each new full assessment.

Definition

Pain: An unpleasant subjective experience that can be communicated to others through self-report when possible and/or a set of pain-related behaviours; it is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Types of pain:

- Acute pain - is relatively brief, and subsides as healing takes place.
- Chronic pain - continues for a long period of time, generally is not curable, and can have episodes of exacerbation whereby certain activities or other conditions may cause the pain to reoccur.
- Neuropathic pain - stimuli abnormally processed by the nervous system.

RAI-MDS 2.0 Definition: Pain that is reported is unrelieved pain. If the resident does not have any pain due to pain management, then it is coded as "0" for no pain.

Note: The following are barriers that can interfere with pain assessment and treatment in the elderly:

- Under reporting of pain
- Choosing to suffer in silence
- Perception of pain by others
- Cognitive functioning
- Fear of losing self-control
- Fear of addiction
- Inability to swallow pills.

Research has demonstrated there is a strong relationship between pain and symptoms of depression, therefore the Depression Rating Scale (DRS) may also be reviewed in the presence of pain.

PROCEDURE:

Pain Assessment & Management

Registered Nursing Staff:

1. Screen resident at least once a day during routine assessments by asking the resident/Substitute Decision Maker (SDM) about the presence of pain, ache or discomfort.

    - Collaborate with resident/SDM, family and interdisciplinary team to conduct the pain assessment utilizing a clinically appropriate instrument within 24 hours of admission
    - quarterly (according to the RAI-MDS 2.0 schedule)
    - when a resident exhibits a change in health status or pain is not relieved by initial interventions.

    SCREENING FOR THE PRESENCE OF PAIN:

    Indicators for completing a pain assessment if any one of the following occurs:

    - states he/she has pain, i.e. 4 out of 10
    - is diagnosed with chronic painful disease
    - has history of chronic unexpressed pain
    - is taking pain-related medication for >72 hours
    - has distress related behaviours (e.g. changes in anxiety level) or facial grimace
    - indicates that pain is present through family/staff/volunteer observation.

2. Collaborate with resident/SDM, family and interdisciplinary team to conduct the pain assessment utilizing a clinically appropriate instrument in Point Click Care - Pain Assessment Tool (Reference pages 12-16 of policy for the “Key for Pain Assessment Tool”); Pain Assessment in Advanced Dementia (PAINAD) Tool and numerical rating

Pain scale. Registered staff is to ensure the appropriate pain assessment and monitoring tools are selected based on the cognitive ability of each individual resident.

3. As per PAINAD policy and procedure, assess psychological and behavioural indicators in the non-verbal, cognitively impaired person such as:
    - flat affect
    - decreased interaction
    - decreased intake
    - altered sleep pattern
    - rocking
    - negative vocalization
    - frown or grimacing
    - noisy breathing.
4. Initiate a written plan of care within 24 hours of admission based on resident's assessed condition and the location, type and patterns of pain episodes, previous history of pain and what was used to manage pain in the past (both pharmacological and non-pharmacological interventions), and contributing factors that may cause pain and allergies. The plan of care will address the treatment of total pain: physical, psychological, social and spiritual.
5. Obtain informed consent for the treatment interventions from the resident/SDM.
6. Complete the care plan within 21 days after admission and continue to update and adjust the care plan based on the RAI- MDS 2.0 assessment. The Pain, Cognitive Performance (CPS), and Communication (COM) scales will inform three (3) questions.
    - Does the resident have pain (Pain Scale); its frequency (J2a) and intensity (J2b)?
    - Is the resident able to communicate the pain (COM)?
    - Is cognitive impairment affecting the ability to communicate (CPS)?

7. Implement strategies to effectively manage pain including pharmacological and non-pharmacological interventions as outlined below.

Pharmacological Management of Pain & Guidelines for Analgesic Drug Orders

The following criteria will serve as a guide for evaluating analgesic orders to ensure appropriate use of analgesics based upon individual resident assessment. These guidelines are taken from the Canadian Palliative Care Standards for acute, chronic and cancer pain management.

Critical Points:

- The Nursing Pain Diagnosis is communicated to the physician so that the appropriate analgesics are initiated. For example, burning, shooting pain has been characterized as neuropathic and often is relieved by an opioid plus an adjuvant drug.

- Drugs used for pain management are based upon severity for pain, and the World Health Organization (WHO) 3-step ladder guideline.

- The **oral** route is the first choice for immediate release analgesic medications. If unable to take oral medications, buccal, sublingual, rectal, and transdermal routes are considered before intramuscular or subcutaneous. For stabilized pain, sustained release oral, rectal and transdermal analgesics may be first choice.

- Residents who report constant pain receive long-acting medications for pain control, and have a short-acting medication ordered for breakthrough pain. Whenever possible the break through pain medication should be the same as the long-acting preparation.

- Long acting oral analgesic agents are not used for the management of acute episodic pain.

- Residents who report intermittent pain have medications ordered on an "as needed" basis. Do not use more than **one combination analgesic** (opioid and non-opioid, e.g., Percocet®, Tylenol #3®) for regular or break through pain dosing.

- Medication for breakthrough pain is calculated at 5-10% of the total twenty-four hour dose and should be the same drug as the long-acting or continuous opioid, and is ordered up to Q1 h prn until pain is controlled.

- Only **one opioid** is ordered for continuous moderate to severe pain e.g., opioid continuous infusion or MS Contin®, OxyContin®, Hydromorph Contin® or Duragesic®.

- Short-acting opioids are ordered at intervals **no longer** than every 4 hours; some circumstances may indicate a need to modify the dosing, e.g. in end-of-life care.

- Consider using adjuvant analgesics for non-opioid responsive neuropathic or bone pain.

- An appropriate plan for bowel regimen is ordered, usually including a stool softener and bowel stimulant.

- A plan is in place for pharmacological and/or non-pharmacological interventions for residents prior to activities that are reported to cause or increase pain.

- Orders for non-pharmacological interventions are present and are clearly stated as part of the interdisciplinary plan of care.

<u>Non-Pharmacological Interventions</u>

The choice of intervention should be based on the resident's preference and the goal of treatment while considering any potential contraindications. Some examples of non-pharmacological interventions are listed below:

- Superficial heat or cold

- Massage

- Relaxation

- Imagery

- Exercise

- Music

- Pressure or vibration

- Psychosocial interventions to facilitate coping

- Cognitive-behavioural strategies plus multidisciplinary rehabilitative approaches
- Psycho-educational interventions

8. Obtain informed consent for treatment when establishing the initial care plan and making changes to the care plan from the resident/SDM.
9. Document the effectiveness of the interventions.
10. A pain monitoring "Pain Level Record" system in Point Click Care (PCC) can be used to monitor pain and determine the effectiveness of the pain management strategies over time. (N.B. Pain Level Record available in orders management of emar).
11. Monitor and evaluate the care plan at least quarterly and more frequently as required based on the resident's condition in collaboration with the interdisciplinary team. If the interventions have not been effective in managing pain, initiate alternative approaches and update as necessary.
12. Consider referral to the palliative care team and/or pain and symptom management consultant for pain that is not well controlled.
13. Communicate to the team and the resident/SDM whenever there is a significant change to the care plan regarding pain prevention on an ongoing basis and annually at the care conference.
14. Refer also to nursing policy and procedures: "Edmonton Symptom Assessment Scale (ESAS), Pain Assessment in Advanced Dementia (PAINAD) Scale, Palliative Performance Scale (PPS), and the Palliative and End-of-Life Clinical Support Tool.

<u>Interdisciplinary Team:</u>

1. Follow the interventions as outlined on the care plan.
2. Recognize and report resident verbalizations and behaviours indicative of discomfort/pain.

3. Report decrease in any of the following: physical and social activity, energy, appetite, continence and sleeping patterns.
4. Share with team members resident interventions that are most effective.
5. Encourage maintenance/restorative/supportive care measures as supported through pain management approaches.
6. Support resident comfort and interests.

Physiotherapist/Occupational Therapist:

1. Implement system assessments as appropriate for musculoskeletal and neurological conditions and contributing pain factors.
2. Develop and implement therapeutic interventions for the assessed conditions.
3. Evaluate and advise the interdisciplinary team of the impact of pain on mobility and Activities of Daily Living (ADL) status and recommend assistive mobility and adaptive aids.
4. Work with resident/SDM to plan and ensure seating and mobility comfort.
5. Encourage resident independence as tolerated.
6. Work with external companies in relation to seating and mobility devices.
7. Work with resident and SDM to ensure that equipment remains in good condition.
8. Educate resident and SDM on approaches that support pain management and resident comfort.

Physician/RN Extended Class:

1. Review medications.
2. Obtain informed consent for the treatment from the resident and/or the SDM.
3. Ensure that the selection of analgesics is individualized to the person, taking into account:

- the type of pain (acute or chronic, and or neuropathic)
- intensity of pain
- potential for analgesic toxicity (age, renal impairment, peptic ulcer disease, thrombocytopenia)
- general condition of the resident
- concurrent medical conditions
- response to prior or present medications.

Dietitian:

1. Complete nutritional risk assessment.
2. Suggest adequate fluid and diet intake to reduce the possibility of constipation.

Resident/SDM:

1. Attend the interdisciplinary care conference.
2. Work with staff for input into, support and evaluation of the plan of care.
3. Residents and/or their representatives are provided, on admission and with changes in pain management, with information about the pain management program.

Monitor and Evaluate

Registered Nursing Staff:

Individual Resident

1. Monitor according to the care plan.
2. Continually monitor resident verbalizations and behaviors indicative of discomfort/pain.
3. Evaluate to determine if pain strategies are effective. The effectiveness of the pharmacological and non-pharmacological interventions will be documented on the appropriate tool(s). If an intervention does not relieve a resident's pain then a pain assessment shall be completed in PCC; and, if required the care plan is to be updated.

4. When a new pharmacological intervention is ordered, or regular dosing is adjusted, for pain management, the Pain Level Record in the eMar will be initiated to determine the efficacy of the medical intervention and ensure appropriate action is taken re: titration or discontinuation of the medication. Pain is monitored at least every 8 hours for a minimum of 7 days following the change or until the pain management goal has been achieved.
5. Documentation to indicate the efficacy of non-pharmacological interventions will be done in Point Click Care progress notes.

Evaluate Policy Effectiveness Annually

The Continuous Quality Improvement; and the Pain and Palliative care teams will:

1. Perform an analysis of the available data related to the pain management program. The type of information to be used in the analysis of the policy may include:
   - Care plan, RAI-MDS 2.0 data and clinical indicators.
   - Trends in data recorded on internal Pain Assessment Tools.
2. Annually evaluate the effectiveness of the policy for managing pain and identify the changes and improvements that are required in the program to improve and maintain optimal functional level and quality of life among residents, and to ensure compliance with the LTCHA and Regulation.

Documentation and Parties Responsible

The following table describes the various forms of documentation required and the parties responsible.

Documentation	Parties Responsible
Informed consent	Physician, RNEC, others to be determined
Written order	Physician, RNEC

Pain Screening Tool	Registered Nursing Staff
MDS-RAI 2.0	Registered Nursing staff for measureable objectives and outcomes
Pain Monitoring Flow Sheet	Registered Nursing Staff
Care plan	Registered Nursing Staff, Interdisciplinary Team
Quarterly reassessment	Physician, RNEC, Registered Nursing Staff
Annual evaluation of the effectiveness of the policy and improvement introduced resulting from the evaluation	Multidisciplinary Team

Staff Orientation

Prior to assuming their job responsibilities, direct care staff must receive training on pain management including pain recognition of specific and non-specific signs of pain.

Training

Direct care staff must receive annual retraining on pain management including pain recognition of specific and non-specific signs of pain.

References:

OANHSS- Ontario Association for Non-Profit Homes and Services for Seniors
Pain Management Program Policy, Procedures and Training Package, December 10, 2010

Fixing Long-Term Care Act*, 2021, &* Ontario Regulation 246/22 Section 53 (4), 57

Key for Pain Assessment Tool

Location of Pain:

As indicated, have the resident, or if necessary, you can place the letter "A" on the part of the body where the resident reports feeling pain. If the pain starts at a certain point then travels, you can indicate the direction and extent of the travel with an arrow. If it seems that there could be a second or third pain, then use the letters "B" and "C".

Intensity:

The resident will be requested to answer the questions in the table as they relate to each identified pain. The preferred pain tool is 0-10. If the resident is finding this confusing or is unable to comply, then use the facial grimace scale as an objective measure.

Quality:

Go over each pain location to identify the appropriate descriptors from the list or if the resident has a different descriptive word, record this beside "other". Indicate the letter that corresponds to the location of pain being described beside the descriptive words.

Effects of pain on activities of daily living (ADL's):

You want to find out if any of the pains identified in the "location of pain" and "intensity" section are affecting any of the activities of daily living listed. Tick "yes" or "no".

If pain is causing a problem in any of the ADL's, indicate in the comments column which pain is causing the problem and in what way.

If pain were not causing a problem in the activity but the resident expresses a difficulty because of some other problem or symptom, you would tick no, but include a comment to elaborate.

It is also important to know if the resident feels that help is needed with any of the activities identified as a problem or if they are content to live with it. If the resident wants help, this would then suggest a need to refer to the appropriate person.

The following are some additional questions and/or points that you may find helpful when asking about the specific ADL areas. Also, included are possible *referrals to the professional(s), who are experts in the different areas.

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1. Sleep and Rest:

   Ask - How often do you wake in the night? How many nights of the week? What is a good or bad night

   What position do you sleep in? Do you use any special positioning devices?

   Have you tried any in the past? Did they work?

   *OT/PT/RN/DR/PC/SW

2. Social activities:

   Includes leisure (hobbies), recreational activities, shopping.

   *OT/SW/Volunteers.

3. Appetite:

   Number and size of meals taken. Food preferences, snacks, an example of how each might help.

   *Dietitian

4. Physical activity and mobility:

   Moving in bed; transfers to bed, chair, toilet; stairs; walking; other exercise; sports; personal care; bathing

   dressing, grooming, eating; medication management.

   *OT/RN

5. Emotions:

   Any change, as a result of the pain, and if so, is this significantly interfering with activities so that

   intervention would be helpful.

   *SW/PC/Volunteer

6. Sexuality and intimacy:

   Is the pain resulting in a significant reduction in desire for sexuality/intimacy or making

   the physical movement required too painful? In both cases, is this a concern for the resident?

   *SW/PT/OT/RN/DR

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Effects of pain on your quality of life:

This can be a very difficult subject to try to describe, which is why some descriptors have been included to assist the resident: happiness, contentment and fulfillment. Have the resident indicate which activity can no longer be done that is important to him/her. Ask how we can help.

Current Medications and Usage:

Include all medications and how ordered; dose, times, number of tablets, how effective using 0-10 scale, regular or PRN, side effects.

Family Support:

This can be any person who is involved in the resident's life and is recognized by the resident as a "significant other".

Symptoms:

Have the resident identify from the listed symptoms which ones are affecting his/her quality of life. Check appropriate ones.

Behaviours:

Have the resident identify disturbing behaviours if possible and/or the assessor will identify and check exhibited behaviour(s).

Past pains:

Have the resident describe the pain incident and his/her coping methods.

Nursing pain diagnosis:

Considering all the information from the assessment, identify one or more pains.
Assign the corresponding letter to relate them to the pains identified in the "Location of Pain" section.

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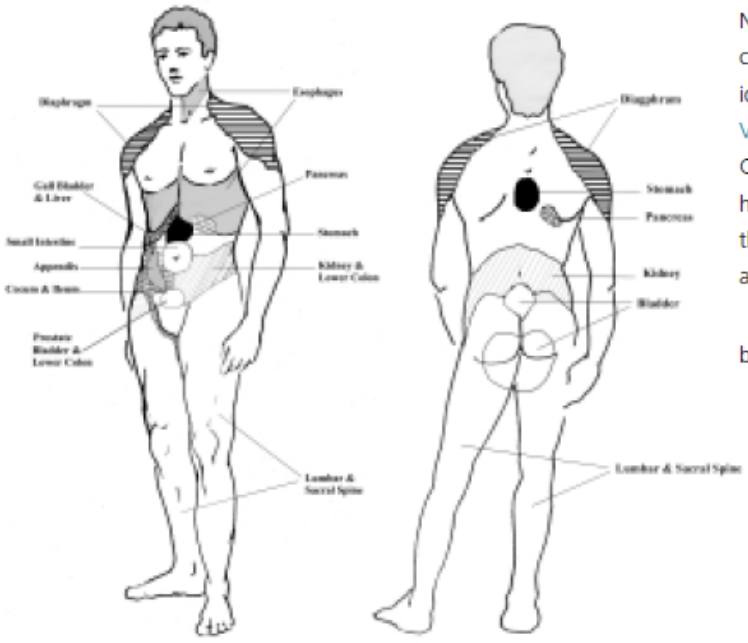
Pain Diagnosis:

There are four classifications of pain; nociceptive pain, neuropathic pain, mixed pain and pain of unknown origin.

Examples of refered pain



1. Nociceptive:

Nociceptive pain is caused by tissue damage created by pressure, infiltration or destruction by an identifiable somatic or visceral lesion.

Visceral:

Constant, dull, aching, poorly localized pain that has a gradual onset often felt at a distance from the origin.

a) Solid Viscera (eg: liver, pancreas)

- if intense, can be sharp and penetrating

b) Hollow Viscera (eg: bowel, bladder)

- diffuse, or colicky pain
- feeling of pressure or fullness caused by blockage of previously open "tunnel"
- may have shortness of breath or cough with thoracic viscera; abdominal distention, nausea, vomiting with abdominal viscera.

Illustrated by: Nancy A. Bauer, BA, Bus. Admin., RN, ET

Reference: [(Phipps, Long & Wood, 1995), cited in McCance & Huether, 1998; Venes, D. 1997]

Somatic:

Constant gnawing or aching, usually well localized, worse on movement or weight-bearing if in pelvis, hips, femur, joints or spine.

- bony metastases
- skin invasion or ulceration
- muscle invasion, soft tissue masses
- pathologic fractures
- osteo-arthritis and other bone destructive diseases
- may be present in back and shoulder if it involves T1

Raised intracranial pressure:

- brain tumours
- meningeal carcinomatosis

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2. Neuropathic:

Neuropathic pain is caused by pressure, invasion or destruction of peripheral or central nervous tissues, which leads to complex and abnormal spinal cord or thalamic neural processes that produce sustained pain.

- invasion, destruction of lumbosacral or brachial plexus
- spinal cord compression
- pain often precedes sensory and motor loss
- constant ache to intermittent, sharp stabbing pain
- specific nerve root compression may cause dermatomal pain
- progressive damage may result in superficial burning pain
- can experience hyperaesthesia, dysaesthesia, progressive motor and sensory loss
- can have vasomotor changes

3. Mixed:

Mixed pain in many instances is a combination of nociceptive and neuropathic pain.

- tumour invasion of pancreas with spread to and destruction of vertebra including spinal cord compression.

4. Unknown:

Persistent pain, the cause of which cannot be determined by history and investigations.

- may be described with all the current word descriptors
- patient is often not believed if investigations are inconclusive
- is usually under treated
- can be debilitating
- lifelong suffering may lead to depression

Problem List:

Using the "Pain Assessment Tool" circle the pain diagnosis(es) and list them on the care plan. If you identify a problem that the resident did not, it is important to ensure the resident agrees and understands why this is a problem. This is an ongoing list. Please date each problem when identified and resolved.

Goals and Plans:

From the problem list, the resident creates goals and you work together to identify the interventions.
It is important to include who specifically will do what and to whom the resident has been referred.
Also, include what outcome measure you will be using to re-evaluate the goal i.e. analog scale of 0 -10 and what tool you will use if it is other than pain. i.e. 0 = no nausea, 10=worst nausea imaginable; or scores from the behaviour checklist.
Include when you anticipate the plans to be carried out and when you will be re-evaluating the goal.
Make sure to sign and date each entry.

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