As a courtesy to those around you, please silence your cell phone and other electronic devices. Excessive disturbances may result in you being asked to either rise and sing our national anthem or babysit my two grandsons. Thank you for your cooperation.

Pain, the Fifth Vital Sign
Chuck Gokoo MD, CWS, FACCWS
Chief Medical Officer
American Medical Technologies
Disclaimer

The information presented herein is provided for educational and informational purposes only. It is for the attendees’ general knowledge and is not a substitute for legal or medical advice. Although every effort has been made to provide accurate information herein, laws change frequently and vary from state to state.

The material provided herein is not comprehensive for all legal and medical developments and may contain errors or omissions. If you need advice regarding a specific medical or legal situation, please consult a medical or legal professional. Gordian Medical, Inc. dba American Medical Technologies (AMT) and the AMT Education Division shall not be liable for any errors or omissions in this information.

Acknowledgement

AAWC
ADAM
American Medical Directors Association (AMDA)
Medscape.com
Program Overview and Objectives

- Discuss the epidemiology of pain in the LTC
- Discuss factors to improve pain management
- Understand pain management instead of reacting to a complaint of pain

Rate of Persistent Pain in US Nursing Homes 2001

Prepared by Brown Medical School Center for Gerontology & Health Care Research

© 2012 AMT Education Division
Quality of Care

Pain

- 50 million Americans are disabled secondary to pain
- 15 - 83% long-term care residents experience some type of pain that impairs mobility, causes depression, and diminishes quality of life.
- 44% of nursing home residents with pain received neither standing orders for pain medication nor special services for pain management.

National Nursing Home Survey, 2004

Prevalence of Pain in Elderly

- 25–56% Community-dwelling older adults
- 45–80% Nursing home residents
- 50% patients dying of a variety of illnesses, including cancer, COPD, CAD
- 31% of women & 19% of men ≥75 yrs report pain in 3 or more sites

AGS panel on persistent pain in older persons, JAGS 50:s205-s224, 2002.
Pain the 5th Vital Sign

Quality of Care

Misconceptions About Pain In the Elderly

Clinician View

- Unrelieved pain is a consequence of aging
- Pain is a punishment for past actions
- Chronic pain indicates the presence of a serious disease
- Acknowledging pain will lead to a loss of independence
- Cognitively impaired residents have a high pain tolerance
- Elderly residents are likely to become addicted to pain medications
Quality of Care

Misconceptions About Pain In the Elderly

Resident View

- Do not report pain or acknowledge that they need something to help manage their pain
  - They are stoic
  - They will be seen as seeking attention
  - Pain is a sign of weakness
  - It may be a problem for busy staff
  - It will subject them to costly or invasive testing

Quality of Care

Pain In the Elderly

Surveyor View

- Interpretive guideline
  - Deficient practices related to pain
- Any resident who:
  - Has pain symptoms
  - Is being treated for pain
  - Has a disease or condition or who receives treatments that cause or can reasonably be anticipated to cause pain
  - Displays possible indicators of pain that cannot be readily attributed to another cause
  - States he or she has pain or discomfort
Quality of Care

Barriers to Effective Pain Management

- Cultural challenges
  - Racial, ethnic, gender bias
- Clinicians
  - Inexperience assessing pain
  - Reluctance to prescribe medications (opioids)
  - Lack of knowledge of how to treat pain and use of non-pharmacological methods
  - “Pain may be the only thing keeping the resident alive”
- Resident
  - Cognitive or functional impairment

- Family
  - Different response
  - Fear of addiction in pain medications
  - Death

- Facility
  - Lack of congruence between residents’ and caregivers’ perceptions of pain
  - Medicare Part D formulary
  - Skill level in using assessment tool

Quality of Care

Facility Education

- Benefits of treatments for pain, risks and limitations of pain medications
- Address misconceptions and myths about pain
- Assist staff to recognize and overcome bias and misconceptions
- Train staff in proper use of pain assessment tools
- Promote a coordinated approach to pain management within the whole facility
Quality of Care

Pain Assessment

- Complete upon admission
- Immediately upon recognition of pain
- Identify risk factors that could relate to pain
  - Cognitively intact and impaired residents
- Identify and document characteristics of the pain
  - Including behavioral symptoms related to pain
- Notify the practitioner
  - Presence of symptoms that may represent pain
  - Obtain appropriate treatment orders

Quality of Care

Cause Identification/Diagnosis

- Use of a standardized scale
  - Quantify the intensity of the resident’s pain
- Identify or clarify specific causes of pain
  - History and physical exam
- Diagnostic testing
  - No specific test for pain
Quality of Care

Management/Treatment

- Identify resident and family pain management goals
  - Guilt, fear and anger
  - Incorporate into the pain PoC
- Manage and treat pain
  - Underlying causes
- Consultation
  - Pharmacist and pain specialists

Quality of Care

Monitoring

- Reassess the status of an individual’s pain
  - Weekly and upon change of pain related condition
- Pain not responding adequately to selected interventions
  - Reevaluate and revise treatment approaches
- Observation
  - Significant effects, side effects, and complications of pain medications
  - Nonspecific signs and symptoms that suggest pain
- Assessment of pain
  - Function and quality of life
Quality of Care

Transdisciplinary Team
- Administrator, Medical Director, DON, Attending physician, CAN, Consultant pharmacist, RD, PT, OT, Nursing staff, Activities staff, Hospice
- Objective, formulated coordinated care
- Care planning (PoC) reflects concerns identified in the pain assessment
- Discuss PoC with the resident and family members or legal surrogate
- Pain reduction - not necessarily pain free

Quality of Care

Pain
- An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage
  - Highly subjective with no objective biological markers
  - Chronic pain is an abnormal condition
- Induces stress and anxiety
  - Leads to a cascade of physiological events that inhibit wound healing
- Three dimensional
  - Sensory - discriminative
  - Affective - motivational
  - Cognitive - evaluative
- Pain is what the resident says it is
**Pain**

- **Causes of Chronic Pain in Residents**
  - Rheumatoid arthritis
  - Knee pain
  - Muscle pain and/or stiffness
  - Immobility, contractures
  - Pressure ulcers (PrUs)
  - Chest pain
  - Degenerative Joint Disease (DJD)
  - Low back disorders
  - Osteoporosis with compression fractures
  - Headaches
  - Oral or dental pathology
  - Diabetic neuropathy
  - PVD
  - Improper positioning
  - Use of restraints

© 2012 AMT Education Division

---

**Pain**

**Pathophysiologic Pain**

- **Visceral**
  - Internal organ damage (associated nausea)
- **Somatic**
  - Muscle or bone pain
- **Neuropathic**
  - Dysfunction in the peripheral nervous system
- **Psych-Social/spiritual**
  - Mental, emotional or behavioral factor
  - Post Traumatic Distress Syndrome (PTDS)
- **Mixed**

© 2012 AMT Education Division
Pain

Types

Acute
- Abrupt onset and limited duration, often associated with an adverse chemical, thermal or mechanical stimulus such as surgery, trauma and acute illness

Background
- Pain at rest (related to wound etiology, infection, ischemia)

Incident
- Predictable and related to precipitating events (walking, coughing, transferring, dressing) or actions (ulcer care)

Breakthrough
- Sudden flare - up of severe pain, associated with inadequate pain medication levels

Persistent or Chronic
- Persists for a prolonged period of time or recurs more than intermittently for months or years

© 2012 AMT Education Division

---

Pain

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Same Key Distinctions Between Chronic and Acute Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain</td>
<td>Acute Pain Recognition</td>
</tr>
<tr>
<td>Recognition</td>
<td>Pain history should raise index of suspicion that pain may recur</td>
</tr>
<tr>
<td>Assessment</td>
<td>Underlying causes usually are already identified</td>
</tr>
<tr>
<td>Treatment</td>
<td>Patient is likely to have a history of efforts at pain management</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Intermittent reassessment is needed based on individual patient circumstances</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Pain is often already receiving some pain treatment</td>
</tr>
<tr>
<td>Acute Pain Recognition</td>
<td>Appropriate management often remains to be determined</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Gradual or progressive selection of analgesics and doses may be appropriate</td>
</tr>
<tr>
<td>Acute Pain Recognition</td>
<td>For more severe pain, higher doses of analgesics may be indicated until pain is controlled</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Patient is likely to have recurrent pain over time</td>
</tr>
<tr>
<td>Acute Pain Recognition</td>
<td>Frequent reassessment may be needed until appropriate medication and dosage can be identified</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Monitoring and management over time are required to determine whether underlying cause of pain can be resolved</td>
</tr>
</tbody>
</table>

American Medical Directors Association

© 2012 AMT Education Division


**Pain**

**Road Block**
- Sleep (increased, decreased)
- Mood (change)
- Appetite (malnutrition)
- Mobility (gait, falls)
- Behavior (change)
- Relationships (socialization decreased)
- Activities (socialization decreased)
- Cognitive functions (confusion, depression, anxiety)
- Quality of life (decreased)

**Action**
- Recognize when the resident is experiencing pain
  - Assessment tool
- Identify when pain can be anticipated
  - Therapy
  - Restorative care
  - Wound care
  - Other treatments
- Evaluate existing pains and their causes
  - Chronic conditions requiring routine pain management
  - Education for families, resident, staff
- Manage or prevent pain
  - Consistent with the resident's goals, comprehensive assessment, plan of care, current clinical standards of practice
Pain

History and Physical

- Existing diagnosis and conditions contributing to pain
  - Body regions and organ systems
- Information from resident’s family or legal surrogate
  - Conflicting reports
- Information from Transdisciplinary team for other diagnosis and conditions
- Current medication history
  - Pharmacist
  - Previous medications

Laboratory Test for Pain

- No specific blood tests that determine the level of pain
- Test to determine whether specific medical conditions associated with pain exist.
  - Fasting Blood Glucose - Diabetes
  - Blood Urea Nitrogen - Renal function
  - Rheumatoid factor (RF) - Rheumatoid arthritis
  - Uric acid - Crystal-induced arthropathy
  - Urinalysis - Infection, urolithiasis, GU disease
  - Spine x-ray - Recurrent compression fracture
**Pain**

**Pain Assessment**
- History of pain
  - When pain may be anticipated
  - Changes in pain characteristics that have been previously assessed
- Prior treatment
  - Pharmaceuticals
  - Non pharmaceuticals
- Effectiveness of prior treatment

**Review of Systems**
- Neurological
  - Weakness
  - Numbness
- Musculo-skeletal
  - Tenderness
  - Inflammation
  - Deformities
  - Decreased range of motion

---

**Pain**

**Pain Assessment (WILDA)**
- What does the pain feel like
  - When possible, allow the resident to choose their own words to describe the pain
  - Sharp, burning, stabbing, dull, aching, throbbing, crushing
- Intensity of pain using valid tool (Numeric, VAS, Verbal)
  - How severe is the pain on a scale of 0 - 10
  - How much does it hurt when it is the worst
  - How much does it hurt when it is the best
- Pain location (all sites)
  - Is it in one place
  - Does it go anywhere else
  - Did it start elsewhere and has it now moved to one spot

© 2012 AMT Education Division
Pain

Pain Assessment (WILDA)

Duration and frequency of pain (constant/intermittent)
- When did the pain start
- How often does it occur
- Has its intensity changed
- How long does it last

Aggravating and alleviating factors (better or worse)
- What causes the pain
- What makes it better
- What makes it worse
- What has been effective in reducing the pain in the past

Cognitively Intact Residents
- Wong-Baker Face Scale
- Numeric Rating Scale
- Visual Analog Scale
- Pain Map
- Memorial Pain Assessment Card
- McGill Pain Inventory
- Brief Pain Inventory
- Multidimensional Pain Inventory
- Wisconsin Brief Pain Questionnaire

Cognitively Impaired Residents
- Pain Assessment in Advanced Dementia (PAINAD)
- Abby Pain Scale
- Doloplus Scale
- Discomfort Scale for Dementia of the Alzheimer’s type
- Checklist of Nonverbal Pain Indicators
- Non-Communicative Patients Pain
- Assessment Instrument (NOPPAIN)
Pain

**TABLE 6**
Example of Standardized Scale for Assessing Pain

<table>
<thead>
<tr>
<th>No pain</th>
<th>Mild pain</th>
<th>Moderate pain</th>
<th>Severe pain</th>
<th>Very severe pain</th>
<th>Worst possible pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Pain as bad as it could possibly be

Examples of pain intensity scales for use with older patients: visual analogue scales.
Sources: American Geriatrics Society; Glath et al.

American Medical Directors Association © 2012 AMT Education Division

---

**WONG-BAKER FACES PAIN RATING SCALE**

<table>
<thead>
<tr>
<th>No Pain</th>
<th>Mild Pain</th>
<th>Moderate Pain</th>
<th>Severe Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

© 2012 AMT Education Division
Pain

Substance Use Disorder

 Addiction
- Drug use despite negative physical and social consequences (harm to self and others) and the craving for effects other than pain relief

 Pseudo-addiction
- Inadequately treated and un-relieved pain leading to persistent or worsening pain complaints, frequent office visits, requests for dose escalations

 Dependence
- The body's adaptation to a particular drug.
- The individual's body becomes used to receiving regular doses of a certain medication

35% of adults ≥65yrs take 8 or more drugs daily

20% of elderly addicted
Pain

Dementia

No evidence that older adults with dementia physiologically experience less pain than other adults (Geriatric Society (AGS) 2002)

Cognitively impaired elderly
- Dementia like symptoms possible due to pain
- May fail to interpret pain
- Less able to recall their pain
- Unable to verbalize

Verbal Descriptor Scale (VDS)

Pain Assessment in Advanced Dementia Scale (PAINAD)

- Analgesics

Pain Assessment in Dementia

- Residents’ self report are still reliable
- Reports from caregivers or family members are also reliable if they are familiar with the resident
- Behaviors exhibited may indicate pain
- Facial pain scale
- Do not use pain scales and ask to recall information from past
**PAINAD**

**Pain Assessment in Advanced Dementia Scale**

<table>
<thead>
<tr>
<th>Items*</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<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>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
</tbody>
</table>

**Total**

---

**Pain**

**Pain Assessment**

- **Behavioral observation**
  - Non verbal symptoms - 1st indicator of pain
  - Aphasic
  - Cognitive abilities (moderate to advanced impairment)
  - Language barrier

- **Define specific treatment goals and risks**
  - Optimal pain control with minimal side effects
  - Assessment of benefits and risks of pain medications resident-centered
  - Determine the best combination of pain assessment tools to use
Pain

Observation
- Non verbalization of pain
  - Constant muttering
  - Moaning/groaning
- Breathing
  - Strenuous
  - Labored
  - Negative noise on inhalation or expiration
- Pained facial expression
  - Clenched jaw
  - Troubled or distorted face
  - Crying

Body language
- Clenched fist
- Wringing of the hands
- Strained and inflexible position
- Rocking

Movement
- Restless
- Altered gait
- Forceful touching
- Rubbing of body parts

© 2012 AMT Education Division

DRIP

<table>
<thead>
<tr>
<th>Causes and conditions that may cause pain (diagnosis or sign/symptom present)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (C929)</td>
</tr>
<tr>
<td>Coronary Heart</td>
</tr>
<tr>
<td>— Angina, Myocardial Infarction (MI), Acute Myocardial Infarction (AMI), Atherosclerotic Heart Disease (AHD), Left Ventricular Failure (LVF)</td>
</tr>
<tr>
<td>— Deep Vein Thrombosis (DVT)</td>
</tr>
<tr>
<td>— Peripheral Vascular Disease (PVD)</td>
</tr>
<tr>
<td>Skin/Scalp</td>
</tr>
<tr>
<td>— Precipitous ulceration (section M)</td>
</tr>
<tr>
<td>— Other ulcers, wounds, incisions, skin problems (W1040)</td>
</tr>
<tr>
<td>Infections</td>
</tr>
<tr>
<td>— Urinary tract infection (G200)</td>
</tr>
<tr>
<td>— Pneumonia (J1800)</td>
</tr>
<tr>
<td>Neurological</td>
</tr>
<tr>
<td>— Head trauma (from clinical record)</td>
</tr>
<tr>
<td>— Epilepsy</td>
</tr>
<tr>
<td>— Neuropathy</td>
</tr>
<tr>
<td>— Post-stroke syndrome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics of the pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
</tr>
<tr>
<td>— Type (constant, intermittent, varies over time, etc.)</td>
</tr>
<tr>
<td>— What makes it better</td>
</tr>
<tr>
<td>— What makes it worse</td>
</tr>
<tr>
<td>— Words that describe it (for example, scorching, burning, sewing, stabbing, shooting, radiating, numbing)</td>
</tr>
<tr>
<td>— Breathing, pulse, and sores, shooting, numbness (neuropathic)</td>
</tr>
<tr>
<td>— Creeping, stinging, throbbing, rubbing (vasovagal)</td>
</tr>
<tr>
<td>— Creeping, tightness (vismill)</td>
</tr>
</tbody>
</table>

Frequency and intensity of the pain (3420, 3430, 3437)
- How often it occurs
- Time or situation of onset
- How long is lasts

Non-verbal indicators of pain (particularly important if unable to speak)
- Facial expression (frowning, grimacing, etc.) (3420C, 3430C)
- Vocal behaviors (crying, moaning, groaning, crying, etc.) (3420A, 3430A)
- Bodily position (guarding, distorted posture, restricted body movements, etc.) (3430F, 3437C)
- Restlessness

Pain effect on function
- Diet (3430C, 3437C)
- Sleep (3430C, 3437C)
- Concentration (from clinical record) |
- Anxiety (3430C, 3437C)
- Fatigue (3430C, 3437C)
- Loss of day-to-day activities (3430B) (social events, using the toilet, etc.) |
- Loss of independence with at least one ADL (3430C, 3437C)

© 2012 AMT Education Division
Pain

Resident’s Medication Record Review
- With each change in pain medication
- With a sudden change in status of the resident
- Consultant Pharmacist
  - Any med changes if recently admitted
  - Any recently discontinued pain meds
  - Drugs poorly tolerated OR giving less than optimal control
  - Any increase in pain related to worsening disease
  - When drug toxicity could be a problem

Pain Management
- Begins on Admission
  - Attending physician
  - Other healthcare professionals
  - Resident
  - Representative
- Resident’s goal for pain management
  - Disease process
  - Nature of the pain
  - Approaches available to manage the pain
  - Need to report pain when it occurs
  - The need to evaluate the effectiveness of the interventions employed
Pain

Pain Management

PoC
- Interventions for managing the pain
- Clinical Standards of Practice
- Responsibility

Interventions
- Source, type and severity of pain
- Available treatment options

Approaches
- Address underlying cause, when possible
- Target strategies to source, intensity, nature of symptoms
- Prevent and minimize anticipated pain

---

Pain

Pain Management

Medicare hospice - End of life
- SNF/NF – primary care giver

Medicare hospice conditions of participation
- Hospice plan of care
- Hospice conditions of participation
- Arrangements for hospice-related inpatient care

Coordination of managed care
- Assessment
- Plan
- Monitor
- Evaluate the resident’s pain management program

---
Pain

Non-Pharmacological Interventions

- Physical modalities
  - Altering the environment
  - Ice packs or cold compresses to reduce swelling and lessen sensation
  - Mild heat to decrease joint stiffness and increase blood flow
  - Transcutaneous Electrical Nerve Stimulation (TENS)
  - Rehabilitation therapy

- Cognitive interventions
  - Soothing, distracting verbal communication
  - Music therapy that uses music preferred by the resident
  - Reading to the resident
  - Activities or recreation

- Complementary and Alternative Medicine (CAM)
  - Physical, cognitive modalities, medications
  - Acupuncture/Acupressure
  - Reflexology
  - Chiropractic or osteopathic manipulation
  - Herbs

Pharmacological Interventions

- Non-opioids (43.3%)
  - Acetaminophen or NSAIDS

- Opioids (7.9%)
  - End-of-life situations
  - Complex pain syndromes
  - Acute and chronic non responding pain

- Adjuvants (49.1%)
  - Neuropathic pain
  - Analgesics (do not address underlying cause of pain)
  - Neurostimulation
Hierarchy of Pain Medications

- **Strong opioids (e.g. morphine)**
  - moderate - severe pain
  - +/- Non-opioid
  - Titrate

- **Mild opioids (e.g. codeine)**
  - mild – moderate pain
  - +/- Non-opioid
  - Titrate

- **Non-opioids (e.g. aspirin, acetaminophen)**

Pain

Prescribing Analgesics (Long Term Care)

- Evaluate the resident’s overall medical condition and current medications regimen to determine the most appropriate pain therapy
- Evidence based recommendations for treatment regimen identified by cause of pain
- Administer at least one analgesic medication regularly (not PRN)
- Least invasive route of administration (swallowing or sublingual)
- Acute pain - begin with a low or moderate dose as needed and titrate more rapidly
- Chronic pain - begin with low dose and titrate carefully until comfort is achieved
- Reassess and adjust the dose to optimize pain relief while monitoring and trying to minimize side affects
Pain

**NSAID**
- Useful in treating inflammation
- Moderate to severe pain control alone or adjunct

**Side Affects**
- GI toxicity
- Renal toxicity
- Cardiovascular risk
- Contraindication
- Liver failure
- Decrease renal function
- Platelet dysfunction

**NSAID**
- Aspirin (acetaminophen)
  - Liver damage
  - Swelling
  - Difficulty breathing

- Aspirin/Ibuprophen
  - Caution use (multisystem toxicity)
  - Adverse gastrointestinal problems

- Cox 2 Inhibitors (adverse affects)
  - Hypertension
  - Renal impairment
  - Edema
  - Vascular disease

---

Pain

**Opioids**
- Moderate to severe pain
- Pain related functional impairment
- Used for both nociceptive and neuropathic pain
- Diminished quality of life due to pain
- Continual or frequent daily pain
  “around-the-clock” time-contingent dosing

- Titrate – no ceiling affect
- Hyperglycemia
- Respiratory depression
- Constipation
- Cardiac arrhythmias (Methadone)
Pain

Opioids
- Can cause drowsiness, nausea, respiratory depression
- Tolerance - diminished effect of a drug associated with constant exposure to the drug over time
- Tolerance develops to CNS side effects
- Tolerance does not develop to constipation
- Prophylax with increasing fluid intake, osmotic laxatives or stimulant laxatives
- Dependency - uncomfortable side effects when the drug is withheld abruptly
- Drug dependence requires constant exposure to the drug for at least several days

Avoid as Analgesic
- Meperidine hydrochloride (Demerol)
  - Confusion or sedation
  - Lower seizure threshold (convulsions)
  - Severe weakness or dizziness
  - Feeling light-headed/fainting
- Pentazocine lactate (Talwin)
  - Delirium and hallucinations
  - Constipation or diarrhea
  - Nausea or vomiting

© 2012 AMT Education Division
**Pain**

**Bowel Regime**
- Daily monitoring of bowel movement
- Juices, fiber, bran, pudding
- Physical exercise
- Opioids - laxative
  - Adjust as opioid is titrated
- No BM in 24 hour period
  - Sorbitol 30mL Q day or BID
- No BM in 72 hours
  - Rectal exam and impaction
  - Phosphate enema or warm water enema

**Communication**
- Use a common vocabulary to describe pain
- Standard pain assessment tool
- Documentation of pain assessment
- Delineation of staff in pain management

**Staffing**
- Consistent staffing
- Recognize pain in cognitively impaired residents
Wound Related Pain Management

- Review resident-centered concerns
  - How does the pain affect the resident’s quality of life?

- Assess etiology of wound
  - Is the pain related to the underlying pathology of the wound (e.g. ischemic pain in PVD in legs)?

- Assess associated complication
  - Pain increased or decreased by complications/co-morbidities and/or by tx interventions (i.e. dressing changes /repositioning?)

Wound Pain

- Presume all wounds are painful
- Over time wounds may become even more painful
  - Accept that for some residents the lightest touch or simply air moving across the wound can be intensely painful

Modify
- The disease state or wound
- The perception of the pain
- Modify or interrupt pain transmission
- Lifestyle
  - Positioning
  - Pressure reducing support surface
  - Reduce resident anxiety
Neuropathic Pain

Trineuropathy

- Sensory, Autonomic, Motor
  - Diabetes, post-herpetic neuralgia, phantom limb pain
  - Steroids, anticonvulsants, opioids, serotonin-norepinephrine reuptake inhibitors (SNRIs, topical analgesics, tricyclic antidepressants
  - Methadone
  - Blocks pain
  - Lidocaine

Adapted from Chronic Wound Pain: A Conceptual Model; Advances in Skin & Wound Care, 21, 4; 175-188, 2008.

© 2012 AMT Education Division
Pain

Preventing Ulcer Trauma and Pain

- External causes of ulcer pain
- Associated with ulcer trauma
  - Ulcer cleansing
  - Dressing changes
  - Sharp debridement
  - Turning and repositioning
- Persistent pain at the ulcer base and the periulcer tissues when nothing is being manipulated, may be attributed to other factors
  - Ischemia or infection

Ulcer Cleansing

- Completed at each dressing change
- Clean with non-cytotoxic, non-irritating cleanser
  - Warm normal saline
- Do not use skin cleansers or antiseptics
- Use irrigation pressure between 4 - 15 psi
  - 35 cc syringe with 19 gauge soft tipped catheter (delivers 8 psi) >15 psi may drive wound fluid & debris into wound
- Reduce excess exudate
Pain

Ulcer Dressings
- Dried out ulcer dressing (gauze) and tissues
  - Irritate local nerve endings
- Non adherent dressings
  - Moisture retentive dressings
  - Hydrogels/hydrofibers/alginate/soft silicons
- Adherent dressings
  - Premature release may cause skin tears, damage tissue, cause pain
  - Hydrocolloids
- Dressing of choice
  - Non traumatic to the wound and surrounding tissues when removed
- Frequent dressing changes
  - Uncomfortable
  - Biologically undesirable
  - Ulcer tissues are chilled and nerve endings are irritated
  - Timely removal

© 2012 AMT Education Division

Pain

Surgical/Sharp Debridement
- Pre-medicate
  - Oral pain meds 45 - 60 minutes
  - Topical 20 - 30 minutes
- Anti-anxiety medication effective as analgesics
- 2% - 4% topical lidocaine gel
- 2.5% prilocaine
- Caution
  - Sensitivity or allergic affect

© 2012 AMT Education Division
Pain

Consider

- Alternatives to surgical or sharp debridement
  - Hydrogels
  - Calcium alginate
  - Enzymatic agents
  - Foams
- Medicate before/during/after as appropriate

Pain medication requires 45 to 60 minutes
- Take pain medication on a regular schedule
- Use complementary therapies
  - Relaxation techniques
  - Warmth or cold on the painful or opposite area
  - Transcutaneous electrical nerve stimulation therapy/music
  - Guided imagery to reduce emotional stress and calm the nervous system
Pain

Amputation

Annual US statistics

- 54,000 lower extremity amputations annually
  - 50 - 70% are preventable
- 50 - 84% of lower extremity amputations are preceded by foot ulcer
- Contralateral limb amputation rate
  - 50% within 4 years
- Mortality rate after amputation
  - 50% - 76% in 3 to 5 years

60% - 90% of amputees

Altered afferent inputs and synaptic changes (CNS)

Stump pain

Risk Factors

- Poorly controlled pre-amputation pain
- Persisting stump pain afterwards
- Bilateral amputations (both legs)
- Lower limb more than upper limb amputations
- Chronic Sciatica
**Pain**

**Phantom limb**

- Treat as neuropathic pain (neuropathy, neuralgia, neuritis)
  - Heat application
  - Biofeedback to reduce muscle tension
  - Relaxation techniques
  - Massage of the amputation area
  - Surgery to remove scar tissue entangling a nerve
  - Physical therapy
  - TENS (transcutaneous electrical nerve stimulation) of the stump
  - Neurostimulation techniques (spinal cord stimulation or deep brain stimulation)

- Medications: pain-relievers, neuroleptics, anticonvulsants, antidepressants, beta-blockers, and sodium channel blockers
- Mirror box therapy

---

**In Closing**

*Never break four things in our lives*

*Trust, Relation, Promise and Heart because when they break they don’t make a lot of noise but pains a lot*

Charles Dickens
Thank you
Questions?

References

American Pain Society at www.ampaisoc.org
Curr. Opin. Rheumatol. 2008;20:239-45
National Initiative on Pain Control at www.painedu.org
References

- Quality Improvement Organizations at www.medqic.org
- Woo KY, Exploring the Effects of Pain and Stress on Wound Healing. Adv Skin and Wound Care 2012;25:38-44.