Pain Management in Long-Term Care

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Definition of Pain

Pain: “an unpleasant sensory/emotional experience associated with actual or potential tissue damage” IASP (International Association for the Study of Pain)

Pain: “Bodily, Mental, or Emotional suffering as due to injury or illness” Random House Dictionary

“Pain: Is whatever the patient defines it to be” Margo McCaffery

Further Definition of Pain

Persistant Pain – Pain that continues for a prolonged period of time and that may or may not be associated with a well-defined disease process
Incidence of Pain

1) Almost half of all nursing home patients have pain
2) 40-50% of patients with pain have moderate to severe pain, while 25-30% have very severe pain.
3) Almost half do not obtain adequate pain relief.
4) Most pain musculoskeletal

Barriers to Pain Management: Physician Practices

1) Misunderstanding regarding
   a) Addiction / Psychological Dependence
   b) Uncontrollable side effects
2) Questioning the genuineness of the complaint.
3) Inability to empathize with the suffering patient.
4) Failure to keep up with scientific advances.
5) Not relating pain to function.
6) Federal and State Legislation.

Barriers to Pain Management: Patient Practices

1) Believe pain is an inevitable consequence of disease.
2) Don’t want to complain and be thought of as a “Problem Patient”
3) Don’t report pain because it is “a sign of worsening disease.” or worry about adverse effect
4) Patient and caregiver worried about addiction.
5) Elderly show atypical signs
6) Chronic pain patient have altered perception of pain
Barriers to Pain Management:

- Nursing Practices
  1. Similar to physician
  2. Fear of giving too much/overdosing
  3. Fear of calling doctor
- Cultural/Societal
  1. Racial/Ethnic/Gender bias
  2. Substance abuse history

Barriers to Pain Management: Facility Practices

1) Inadequate communication
   - unaware of tools available to assess pain especially in cognitively impaired patient
2) High-turnover of caregivers
3) Regulatory issues
   - need to have good process for getting controlled substance meds for patients (many parties involved - hospital/docs/NP/PA/pharmacy)

Etiologies of Pain

1) Organic Factors
   a) Nociceptive: (Nociceptors involved)
      - Somatic (Bone, Soft Tissue, Muscle, Skin)
      - Visceral (Cardiac, Lung, GI Tract, GU Tract)
Etiologies of Pain cont...

1) Organic Factors cont...
   1) Neuropathic:
      a) Pain associated with nerve destruction; direct invasion of nerve by virus or tumor
      b) Symptoms include a “burning or stinging” pain

Etiologies of Pain cont...

3) Psychosocial Influences:
   - Loss of work
   - Physical disability
   - Fear of death
   - Financial concerns
   - Psychological state
   - Depression

Assessment of Pain - History

1) Location
2) Onset
3) Duration
4) Type
5) Intensity

   - Patient’s self report should be the primary source of assessment
Signs/Symptoms Pain

1) Verbal – pt states, moans, cries, yelling/combative
2) Non-verbal – loss of function, eating/sleeping poorly, agitation, change in sleep, sad, loss of interest in activities/therapy, facial grimacing
3) see list from AMDA Clinical Practice Guideline
4) use scales (faces/ numeric scale) (verbal descriptor scale- mild/mod/severe)

Pain and Nursing Home Documentation

- MDS
  1. Five day look back
  2. Quality of Life
  3. Scheduled/Prn and non-med pain intervention
- Quality Indicators/Public Reporting

AMDA Clinical Practice Guideline

- Step 1- Recognition – Is Pain Present?
- Step 2 – Have characteristics of and likely causes of pain been adequately defined?
- Step 3 – Provide appropriate interim treatment for pain
- Step 4 – Perform a pertinent H&P exam
- Step 5 – Are cause(s) of chronic pain identified?
- Step 6 – Perform further diagnostic testing
- Step 7 – Are cause(s) of pain identified?
AMDA Clinical Practice Guideline

- Step 8 – Obtain add’l evaluations/consultations as needed
- Step 9 – Are cause(s) of chronic pain identified?
- Step 10 – Summarize the characteristics and causes of the patient’s pain and assess the impact of pain on function and quality of life
- Step 11 – Adopt a patient-centered interdisciplinary care plan

AMDA Clinical Practice Guideline

- Step 12 – Set goal for pain relief
- Step 13 – Implement the care plan
- Step 14 – Re-evaluate the patient’s pain
- Step 15 – Adjust treatment as necessary
- Step 16 – Is pain controlled?
- Step 17 – Monitor facility’s performance in management of pain

Pain Management

The WHO Ladder (1990) - Five Essential Concepts:
1) By the mouth
2) By the clock
3) By the ladder
4) For the individual
5) With attention to detail
The WHO Step Ladder
Freedom from pain
Opioid + Non-Opioid + Adjuvant
Pain persisting or increasing
Weak Opioid + Non-Opioid + Adjuvant
Pain persisting or increasing
+ Non-Opioid + Adjuvant
Pain

Step One: Non-Opioids
- Acetaminophen
  - Well tolerated / many routes
  - Toxicity risk / esp. in pts with hepatic disease
- NSAIDS
  - Prostaglandin inhibition - for inflammation / bony pain
  - Toxicity: Gastropathy, Fluid Retention, Renal Failure,
  Platelet Dysfunction
  - Limit use in elderly
- Cox-II Inhibitors: Celebrex
- Steroids

Step Two: Weak Opioids
- Add weak Opioid to step one Rx
  i.e. - Codeine  (Tylenol #3, #4)
  Hydrocodone  (Vicodin, Lortab, Norco)

Problem:
Most compounded with acetaminophen which can
limit usefulness due to dose-related toxicity
Better now with 325 mg acetaminophen/hydrocodone
tabs
Step Three: Strong Opioids

- Morphine: = Gold Standard
  - Multiple routes/oral most common
  - Stigma associated with name
- Hydromorphone
  - 5x more potent than Morphine
- Oxycodone
  - Expensive
- Fentanyl – long-acting
- Do Not Use Meperidine (Demerol)
- Methadone – becoming more common

Step Three: Additional Opioid Use

- Tramadol (Ultram/Ultracet)
  - Used frequently in UK, use in U.S. growing
  - Start low dose 50mg bid, titrate slowly
  - Can cause delirium in elderly but less likely if start low and titrate slowly

Opioid Side Effects

- Prepare Patient and Family
- Constipation
  - Opioid receptors in gut
  - Use motility drug Rx - start tx when start opioid
Opioid Side Effects
- Nausea and Vomiting and Pruritis
  - Should resolve with time, can treat temporarily
- Sedation and Confusion
  - Warn patient/family, should resolve with time
  - ?Ritalin to counteract in terminal patients

Opioids and Respiratory Depression
- Usually only at higher doses
- Usually not a problem with patients on long term opioid therapy due to tolerance
- With pain abruptly relieved may get hypoventilation, can usually be prevented with physical stimulation
- Use opioid antagonists cautiously
- May be a benefit in terminal patients
- Discuss with family

Opioids and Tolerance
- Tolerance = the need to increase dose requirements over time to maintain pain relief
- First indication is decrease in duration of analgesia for current dose
- In cancer patients, often means progression of disease
Opioids and Physical Dependence
- Occurs in all cases of prolonged use
- Physiologic etiology
- If medications not managed appropriately can get withdrawal syndrome, but this is not a sign of addiction
- Less concerning with treating pain in terminal patients

Opioids and Addiction
- Psychological dependence - lifestyle is geared to acquisition of drug
- Patient loses control of use of drug
- Use continues despite of losses
- Medication does not improve quality of life, regardless of dose
- Rarely occurs in terminal illness

Adjuvant Pain Management cont...
Neuropathic Pain Treatment
1) Antidepressants (Amtriptylene most common) - titrate doses slowly
2) Anticonvulsants (Dilantin, Tegretol, Neurontin)
3) Local anesthetics - Antiarrhythmic (Lidocaine, Mexilitene)
Adjuvant Pain Management cont. . .

- Anxiety – use benzodiazepenes scheduled
- Insomnia – sometimes sign of pain, can use long acting pain Rx just at night; or treat insomnia (Desyrel, Restoril, Melatonin) as can make pain worse if pt. not sleeping (schedule if using regularly or if demented)
- Gaseous Distention – Mylicon tabs
- Muscle Spasm – Flexeril, Baclofen prn or scheduled

Placebos

- Placebos are effective in a portion of patients for a short period of time only and should not be used in management of pain in cancer or elderly
  - AHCPR Guidelines

Parenteral Opioids

- Indications:
  - Dysphagia
  - Uncontrolled Nausea and Vomiting
  - Patient refusing oral/rectal route
- IV use becoming more common in nursing home
- Subcutaneous important use in nursing home
- Morphine/Dilaudid most common
Topical Agents

- Capsaicin Cream (Zostrix)
  - Extract of red pepper
  - Localized depletion of substance P
  - Good for post-mastectomy patients, diabetic neuropathy, post-herpetic neuralgia

- Lidoderm Patch (5%)
  - Apply to joints or any site of pain where patch can stick
  - Can cut in half/pieces and apply
  - Apply in am or pm and remove after 12h

Non-Pharmacologic / Non-Invasive Treatment of Pain (Complementary and Alternative medicine – CAM)

1) Physical Modalities
   - TENS
   - Acupuncture
   - Massage
   - Cutaneous stimulation (Heat / Cold)
   - Exercise
   - Therapy

2) Psychosocial Interventions
   - Imagery
   - Aromatherapy
   - Relaxation techniques
   - Art / Music Therapy
   - Bio-feedback
   - Hypnosis
   - Meditation
Pain in the Elderly

1) At-risk for under-treatment of pain due to inappropriate beliefs about their pain sensitivity, pain tolerance and ability to use opioids.
2) Due to increased incidence of cognitive impairment in elderly, they may require more frequent pain assessment or scheduled pain Rx.

- AHCPR Guidelines

Pain in the Elderly, cont . .

1) Immobility
2) Oral and Dental pathology
3) Post-stroke syndromes
4) Pressure ulcers
5) Trauma
6) Urogenital conditions – (i.e. bladder distention, constipation)

Co-existing Syndromes Related to Pain

1) Depression
   - Common in patients with chronic pain
   - Can worsen pain symptoms
   - Get psych involved in chronic pain at times
2) Anxiety
   - xanax most common
3) Agitation/Delirium – common end-of-life
   - Haldol most common (0.5mg)
4) Suicide – take seriously
### Process Guidelines for Pain Management

- **Assessment and Problem Recognition**

1. Did the facility document that an assessment for pain was begun within 24 hours of admission or recognition of a condition change?
   - Does facility periodically ask resident if having pain, at least at time of vital signs?
   - Recognize non-verbal signs of pain?
   - More often in patients with known painful condition(s)?
   - Interdisciplinary team – anyone can identify pain – the earlier the better
   - Nursing assistants can identify pain

2. Did the facility recognize any triggers for pain on the Minimum Data Set (MDS)?
   - Listed on AMDA Pain Management Guidelines
   - Especially non-verbal signs of pain
   - Did MDS team relay noted signs of pain to physician/extender/nurse, etc? (My question)
Process Guidelines for Pain Management

- Assessment and Problem Recognition
  1) Did the facility consider the significance of risk factors that could reflect pain or the risk for having pain?
     1) Pain evaluation needs to be initiated regardless of symptoms if new admit already taking analgesics
        - review effectiveness of treatment
        - evaluate for reduction or escalation of pain treatment
        - especially in resident with condition that increases risk of having pain

- Assessment and Problem Recognition
  1) Did the facility identify and document characteristics (onset, location, intensity, etc.) of pain?
     1) frequency, what makes it better/worse – assess within one week of initial identification of pain and periodically thereafter
     2) use standardized scale
     3) help physician determine appropriate treatment, (i.e. burning pain may be neuropathic)

- Assessment and Problem Recognition
  1) In someone who could not verbalize pain symptoms, did the facility attempt to use alternate means to identify possible pain?
     1) Specifically in cognitively impaired individuals use alternate means to inquire or investigate for possible pain – (non-verbal signs of pain)
     2) Very pertinent during times of positioning
     3) Often pain in cognitively impaired undertreated
     4) Evaluate for conditions such as delirium, electrolyte imbalance as well
Process Guidelines for Pain Management

**Assessment and Problem Recognition**
3. Did the facility notify a physician or physician extender of the presence of symptoms that may represent pain?
   1. Expect physician to review the situation and prescribe or modify an interim regimen within 24 hours of identifying the presence of unrelieved pain, or maximize comfort while working up new pain.

**Diagnosis/Cause Identification**
3. Did the facility try to identify or clarify specific causes of pain?
   1. Determine whether causes of pain have been identified or whether investigation warranted.
   2. Use summary of characteristics of pain and causes of pain to create related care plan.
   3. Many diagnoses in long-term care patient can cause pain.

3. Did the physician or physician extender participate in identifying specific causes of pain, to the extent that a likely medical cause or no cause was identified?
   1. Show that a physician or practitioner took relevant medical history and evaluated pain - especially in cases where pain worsening, severe or not responding to treatment.
   2. Cases where pain is impairing function (my comment)
   3. Sometimes cause cannot be identified.
Process Guidelines for Pain Management

- **Diagnosis/Cause Identification**
  1. If the resident was not evaluated for causes of pain, does the facility explain why there was not an evaluation, or why an evaluation would not have changed the management?
     1. Not always possible to find cause of pain and facility/practitioner should explain why further work-up not done or explain why cause could not be determined (i.e. terminal patient)
     2. Several causes for pain may co-exist or new cause may be equally or more relevant than preexisting conditions
     3. Needs to be documented

- **Treatment/Problem Management**
  1. Is there evidence that interventions to manage pain were initiated at the time of recognition?
     1. Evidence that attempts were made to create a relatively comfortable environment for resident with pain
     1. Look at AMDA Pain mgmt CPG – complementary therapies – offer those relevant to individual resident
     2. Reassuring words/touch, music, topical analgesic or low-risk oral analgesic

- **Treatment/Problem Management**
  1. Did the facility identify a goal for pain management in someone with pain?
     1. Total pain relief not always possible and is not realistic goal for any patient
     2. Facility needs to establish goal for pain for each individual and describe how decided on these goals (i.e. pain <4 - whatever patient’s tolerable level is, reduce need for breakthrough pain meds, improve function)
     3. Interdisciplinary approach to setting goal including input from resident (when able), family and staff
Process Guidelines for Pain Management

**Treatment/Problem Management**

1) Does the care plan contain cause-specific or symptomatic interventions, where appropriate, targeted to an individual’s conditions, risks, ability to cooperate, etc.?

1) Explain basis for individual pain management looking at individual's diagnoses, conditions contributing to pain, resident's ability to tolerate meds, swallow, etc., including his/her preferences or wishes as expressed in an advance directive

2) Show that physician and interdisciplinary team have communicated and reviewed causes, characteristics and options, including non-pharmacologic measures (may reduce need for meds/side effects, etc.)

3) Did the physician or physician extender help identify or authorize symptomatic or cause-specific interventions, as indicated?

1) Show that followed basic principles of using analgesic medications in the frail elderly and chronically ill (listed in AMDA pain management CPG)

2) Recognize that the elderly may often have adverse reactions to meds

3) If not follow, explain why not

4) If patient receiving pain meds such as propoxyphene, meperidine, pentazocine or butorphanol which are not recommended in elderly, expected to change med or document why not

4) Example – using narcotics first line for minor pain
Process Guidelines for Pain Management

● Treatment/Problem Management

1) Did the facility consistently implement a care plan that included appropriate symptomatic and cause-specific interventions?

1) Individualize giving medications at time that meets patient's needs – (giving meds before activities that cause pain such as activity, dressing change, etc.)

2) If patient regularly using PRN pain medications, expected that meds switched to scheduled pain meds or explain why PRN regime was maintained

3) Scheduled med may be needed in resident who can’t ask for pain meds

● Treatment/Problem Management

1) Did the facility document a reason for not implementing or continuing potentially appropriate interventions?

1) If resident or substitute decision-maker refuses offered pain relief measure, we expect you to document that and show that you have considered basic potentially correctable reasons for such refusal such as unpleasant medication side effects

2) With discussion with patient/family you may be able to reach an alternative pain regime acceptable to everyone

● Monitoring

3) If pain did not respond adequately to selected interventions, did the facility consider alternatives?

1) Show that if pain not controlled with current treatment to tolerable level that alternative treatment methods were considered or explain why not/explain why continue current treatment

2) Some alternatives may not be relevant or may present too great of a risk to a given individual.
Process Guidelines for Pain Management

- Monitoring
  - Did the facility periodically reassess the status of the resident’s pain?
    1) Evaluate effectiveness of interventions and status of person’s pain over time using consistent approaches and tools as in the initial assessment
    2) Periodically review whether and to what degree pain is affecting important aspects of quality of life such as ability to perform ADLs, sleep, participate in usual activities, mood, behavior, cognition
    3) Regularly assess for new onset of pain
    4) Pain may improve and analgesics can be tapered or stopped

- Monitoring
  - Did the facility monitor periodically for significant effects, side effects and complications of pain medications?
    1) Show that you have adjusted the dosages of analgesics to try to meet goals for pain mgmt that were established as part of the care plan, limited by side effects or potential toxicity
    2) For residents with pain symptoms resolved it is expected to be considered why meds need to be continued or evaluate for tapering/stopping, especially if pain stable for more than three months or evidence of side effects
    3) Monitor for complications

- Monitoring
  - Did the facility address significant adverse drug reactions related to pain medications or document why it was not feasible or relevant to do so?
    1) Monitor for, manage significant complications of analgesics and adjust meds to balance therapeutic effects with undesirable side effects such as lethargy, confusion, anorexia or increased falls
    2) Document why adjustment not made if indicated, i.e. significant side effects were considered less important than the primary goal of pain relief
    3) Resident must be monitored for potential worsening of the complication
Medical Director Role in Pain Management

1) Write & Review policies (review annually)
2) F157 – notification of change
3) F501 – medical director
4) F428 – Medications, drug regimen review
5) F332-333 – medication errors
6) F309 – Quality of Care – recognition and management of pain

Take Home Points

1) Facility Preparedness
   - Communication – specific pain goals, appropriate assessment scale, regular pain assessment, include direct care staff, QI
   - Education – regular training staff, AMDA "Know-It-All Diseases Awareness Series:
   - Staffing – allow staff to remain with same patient(s), active participation of nursing staff with choice of scales, process

In Summary

1) Relate pain to function
2) Know what your assessment and re-assessment approach to pain management is
3) Know what your treatment approach to pain management is
4) Educate your patients and families about their role in pain management
5) Educate your staff
6) Anyone should be able to tell dr. about pain