

POSTette: Pain Management

Reference: Medicare Benefit Manual Chapters 8 & 15; APTA; AOTA

Pain is a common problem for adults 65 and older. According to Zancocci et al., 2008, up to 80% of skilled nursing residents experience pain regularly, however, pain is often under treated. Persistent pain has been associated with functional impairment, falls, slow rehabilitation, depression, anxiety, decreased socialization, sleep disturbance, as well as increased healthcare utilization and costs.

Assessment Considerations:

- Assess on every evaluation (if pain indicated be prepared to address it in the POC and treatment).
- Determine the cause of the pain
 - Identify medical diagnoses related to the pain: underlying diagnoses causing pain (for example; osteoarthritis, cellulitis, diabetic peripheral neuropathy, etc.)
 - Pain type (acute, neuropathic, visceral, etc.), intensity, impact on quality of life and function
 - Medical comorbidities contributing to pain and/or affecting treatment
 - Cardiovascular, cerebrovascular or neuromuscular diseases
- Rate pain using various scales including non-verbal and cognitively impaired patients. (Use the same scale when comparing data throughout treatment.)
- Indicate medications (if any) and dosage that are being utilized. (Coordinate meds and treatment times).
- Note psychosocial issues and patient's ability to cope with pain
- Determine factors that impact treatment planning and may affect response to treatment (i.e. depression, anxiety, negative emotions, past experiences, illness perception, etc.)
- Determine how much pain is effecting the patient's ability to function. Determine the skilled interventions needed.
- Develop a Pain Management Plan with the IDT
- Establish goals around pain reduction or indicate why pain won't be addressed with current POC.

Document any functional activity limitations/participation restrictions due to pain especially as it relates to patient goals.

For Example:

- Self-Care (inability to eat due to TMJ pain; inability to perform LB dressing due to back pain, etc.)
- Domestic Life (inability to shovel snow or walk to mailbox due to pain)
- Education life (inability to concentrate due to pain)
- Community, social, civic life (inability to function due to back pain, inability to play with grandchildren because legs ache while walking)

Pain Scales:

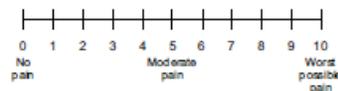
- **Visual Analogue Scale** -The intensity of pain is rated on a line marked from no pain at one end, to as bad as it could possibly be at the other end. Can be used with most patients, caution with cognitive impairments.

Visual Analog Scale (VAS)*



- **The Numeric Rating Scale (NRS)** is a tool to rate the intensity of pain on a scale from 0-10. The Verbal Numeric Rating Scale may have a limited role for communication or cognitively impaired patients. NRS can be more effective when combined with repeated assessments to determine the efficacy of pain interventions.

0-10 Numeric Pain Intensity Scale*



- **Faces Pain Scale** - Many geriatric patients who are cognitively impaired or don't speak English, can't understand or relate to the popular zero-to-10 numerical pain rating scale. In these cases The Faces Pain Scale is more effective. The scale usually has six faces ranging in expression from smiling to crying, and they carry numbers from 0 to 5 which would be assigned to a pain level (Kim, Buschmann, 2006).



- **The Pain Thermometer** - Patients can simply point to a word which resembles how they are feeling at that time. Enhanced visual cues may help with patient ratings.

Pain Thermometer Scale

Point to the words that best show how bad or severe your pain is NOW



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- **Pain Assessment in Advanced Dementia (PAINAD)** used to recognize and evaluate pain in the vulnerable Dementia population. Elderly dementia clients who have pain are often under-recognized and under-treated comparing to those patients that do not have cognitive impairment.

Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
Total**				

- **Verbal Descriptor Scale** uses words instead of numbers. The clinician could say, "Would you please describe your pain for me, from 'no pain' to 'mild,' 'moderate,' 'severe,' or 'pain as bad as it could be'?". Interpreting the results of the verbal descriptor scale should focus on the words used to describe the pain.

Instructions: Please place a check mark next to the phrase that best describes the current level of your pain.

- The Most Intense Pain Imaginable
- Extreme Pain
- Severe Pain
- Moderate Pain
- Mild Pain
- Slight Pain
- No Pain

Remember: Pain is a subjective experience (the experience is unique for each individual person) with a different meaning to each person. Changes in pain intensity are valuable when measured for single individuals (for example, before and after a treatment), but they should not be used to compare pain between different individuals. One person's 4/10 might be another's 10/10.

Treatment Considerations:

- Coordinate pain medication around treatment sessions.
- Assess and document pain levels and response to treatment in treatment encounter notes (Use the same scale each time).
- Provide skilled interventions to address pain identified at evaluation
 - Document what interventions decrease pain
 - Document what interventions increase pain
- Rate the pain pre and post treatment sessions using the same scales. Indicate which treatment approaches yielded the best results in pain reduction.

- Follow the pain management plan and communicate modifications to the plan with nursing and at IDT meetings
- Review the pain management plan with IDT
- Document progress toward pain reduction goals

Non Pharmacological Interventions:

- Complete patient interviews to determine what non-pharmacological approaches they used in the past (what worked / what didn't)
- Utilize Modalities (see various Modalities POSTettes for additional clinical and payer information)
- Provide Manual Therapy Techniques
- Utilize Therapeutic Exercise for ROM / Flexibility/ Strength
- Determine best seating / positioning & support surfaces
- Integrate breathing/relaxation strategies
- Cognitive-behavioral approaches can be effective for the Dementia population and may include such relaxation techniques, distraction / behavior modification, and music therapy. Cognitive-behavioral strategies can help patients alter their pain behavior and coping skills.

Additional Documentation Considerations

- Activities or postures that aggravate pain
- Sensory and Temporal qualities of pain
- Somatic distribution/mapping of pain
- Severity of pain/soreness and discomfort related to activities and/or participation

The major goals of acute pain are control and relief while efforts are made to identify and treat the underlying disease and to enhance healing and recovery. Treatment needs to focus on decreasing the intensity of acute pain in an effort to reduce or prevent permanent changes in the nervous system that may result in chronic pain.

Chronic pain sufferers can also benefit from an IDT pain management approach with goals of improvement in function and quality of life.

In all cases, IDT communication is critical for pain management success.

An active pain management plan will help patients address what to do if their pain worsens and sets them back. An individualized plan for pain, sleep, stress, and social roles should all be included in the plan of care and IDT approach. It is important to emphasize that pain can affect thinking, influencing whether a patient will have a "good day" or a "bad day." Goals should be patient-specific, developed with the patient, incorporate into daily activities, and be modified regularly.