Pain assessment and management

Resident with any of:

- New or uncontrolled pain
- Diagnosis of a condition known to commonly cause pain
- Recent fall or trauma
- A change in behaviour or psychomotor activity of the resident compared to normal
- A sudden change to resident mobility

1. Assess pain using a cognition appropriate approach (see Practice point 1).
2. Where resident presents with fever or localising signs of infection, isolate resident and place under standard and transmission-based precautions until GP review.
3. Check vital signs - review Recognition of the deteriorating resident.
4. If not immediately life-threatening, review Checklist for contact and verbally contact GP*.

UNSTABLE VITALS

Review advance care plan and refer to Management of residents with unstable vital signs

STABLE VITALS

Undertake structured assessment to:

- Determine cause of pain (see Practice point 2)
- Classify the type of pain (see Practice point 3)

Identify and escalate Red flags for deterioration (see Practice point 4)

RED FLAGS PRESENT

RED FLAGS ABSENT

1. Where cause of pain has been identified, treat underlying cause in consultation with the resident's GP; where relevant, refer to related pathways (e.g. for chest pain, review Chest pain pathway; for pain after a fall, review Falls pathway).
2. Establish a pain management plan in consultation with the multidisciplinary team, resident and where applicable, the resident's nominated decision support person (see Practice point 5).

FAILS TO IMPROVE

IMPROVES

Assess for Escalation criteria (see Practice point 6)

ESCALATION CRITERIA PRESENT

ESCALATION CRITERIA ABSENT

1. Regularly review to assess and monitor for:
   - Need for ongoing analgesia
   - Escalation of analgesia
   - Development of red flags or escalation criteria
   - Development of side effects from analgesia
2. Any resident who has ongoing analgesia prescribed must have this regularly reviewed with appropriate weaning and deprescribing where this is no longer indicated.

DEVELOPS RED FLAGS

DEVELOPS ESCALATION CRITERIA

At GP discretion and in consultation with resident:

1. Where the resident has palliative goals of care, refer to **HHS palliative care services**.
2. Where pain is chronic and resident does not have palliative goals of care, refer to HHS chronic pain service.
3. Otherwise, refer to **HHS RaSS**.

*Where timely, arrange telehealth or face-to-face GP review

Pain assessment and management practice points

1) Cognition appropriate pain assessment

Pain assessment should be undertaken using a self-reported pain assessment tool by the resident where the resident is able to communicate. Initial assessment is ideally undertaken via a multidimensional pain tool (e.g. Modified Resident's Verbal Brief Pain Inventory). This is a biopsychosocial scale specifically designed for assessment of pain in residents of aged care facilities.

Once a comprehensive pain assessment has been completed, a unidimensional pain assessment scale can be used for ongoing evaluation of pain and response to management.

If the resident is able to communicate, use either of the following tools:

- Numeric Rating Scale (where the resident rates pain on a scale of zero to ten, where zero indicates no pain and 10 indicates the worst pain imaginable)
- Verbal Descriptor Scale (where the resident categorises their pain by severity descriptors: no pain, mild pain, moderate pain, severe pain, very severe pain or worst possible pain)

If the resident is unable to communicate, use one of the following tools:

- PAINAD scale (where residents are observed for 5 minutes for assessment of breathing independent of vocalisation, negative vocalisation, facial expression, body language and consolability)
- Abbey Pain Scale (where residents are assessed for severity and frequency of observed vocalisations, facial expressions, changes in body language or behaviour and physiological or physical changes)
- PainChek integrated pain assessment (an electronic pain assessment instrument)

2) Structured assessment of the resident with pain

This may be initiated by any RACF clinician with the resident and their nominated support person or family and with involvement of the GP for further assessment, investigation and management. The goals of structured assessment of the resident with pain are to:

1. Assess the severity and impacts of the pain on the resident.
2. Classify type of pain (see Practice point 3).
3. Determine the underlying cause of the pain.
4. Inform the development of a multidisciplinary pain management plan.

History:

- **Pain history:**
  - Onset and timing - when did the resident first notice this pain, has it changed since onset
  - Location and radiation of pain - where in the body the pain is felt
  - Nature of pain (e.g. dull or stabbing or tearing)
  - Severity of pain using appropriate pain assessment tool
  - Aggravating factors or what makes the pain feel worse
  - Relieving factors (e.g. specific position or rest)
  - Impact of pain on sleep, appetite, activities of daily living, social activity
  - Goal of management (e.g. to find and treat underlying cause, to eliminate pain, to reduce pain to allow daily activities)
- Further history to determine cause:
  - Identified precipitating event (e.g. trauma / fall)
  - Associated symptoms (e.g. fever, vomiting, constipation, rash)
  - Medical history (e.g. rheumatoid arthritis, metastatic cancer, ischaemic heart disease etc.)
  - Psychosocial history

Examination:
This should commence with reassessment of vital signs.

- Look:
  - Does the resident look unwell?
  - How is the pain appearing to impact the resident? E.g. Is the resident:
    - Splinting their breathing

Pain assessment and management practice points (cont'd)

2) Structured assessment of the resident with pain (cont'd)

    - Restricting movement
    - Limping
    - Rubbing the sore spot
  - For residents unable to communicate, perform a pain assessment using an appropriate observational pain tool
- Listen:
  - For residents able to communicate, use an appropriate verbal report of pain
  - Focused examination of area of maximal pain (e.g. listen to chest for focal findings in chest pain)
- Feel:
  - Gently palpate, commencing with examination of the area most likely to be related to the source of pain (e.g. for abdominal pain commence examination of the abdomen or for limb pain, gently palpate the limb) to determine the likely source of pain
  - Always examine the area of interest commencing at the point most distant from where the resident reports pain is maximal (e.g. if the resident has right iliac fossa pain), commence palpation of the abdomen in the left upper quadrant
  - Where the resident has limb pain, examine the pulses and capillary refill time of the limbs

Investigations:

- The history, examination and resident goals of care will inform any required further investigations - these should be determined in consultation with the resident and their GP

3) Classification of the type of pain

Determining the type of pain can inform best practice approaches to pain management. Pain may be classified by mechanism and duration. It is important to understand whether pain is new (acute) or chronic - where pain is chronic it may be accompanied by intermittent exacerbations.

Mechanism of pain

Whilst there are three main mechanisms of pain, it is important to note that pain may be contributed to by multiple mechanisms (e.g. cancer pain). Pain may be classified by mechanism as:

A. Nociceptive pain - caused by injury and / or inflammation. It is most often acute pain. Nociceptive pain is further classified by location and description.

B. Neuropathic pain - caused by nerve damage (such as in shingles or post-herpetic neuralgia, diabetic neuropathy) or by nerve compression (e.g. disc prolapse). It is often a chronic pain.

C. Nociplastic pain - caused by neurological dysfunction that results in sensitisation of nerves to pain (e.g. fibromyalgia, complex regional pain syndrome and tension headaches).

Duration of pain

Pain may also be classified by duration (acute versus chronic). Acute pain may be recurrent as the underlying disease process fluctuates (e.g. rheumatoid or osteoarthritis). Chronic pain is defined as "pain that lasts or recurs for longer than three months" (Treede, 2019).

Pain assessment and management practice points (cont'd)

4) Red flags for deterioration of the resident with pain

Red flags for deterioration of the resident's pain should prompt referral to the resident's advance care plan and the Management of residents with unstable vital signs pathway.

Red flags include:

1. Pain due to a condition requiring hospital based investigation and / or management in residents, where such care is concordant with resident goals of care.
2. Rapidly escalating pain and / or rapidly escalating opioid requirements.
3. Acute severe pain with new change in resident's mobility.

5) Multidisciplinary pain management plan

Pain management plans should be individualised and developed in collaboration with the resident, their nominated decision support person and a multidisciplinary team.

The most effective management plan is one that:

1. Is individualised to the resident's goals of care and is tailored to meet the resident's pain care goals.
2. Treats the underlying cause of the pain (where this is treatable).
3. Is tailored to the type of pain (nociceptive versus neuropathic, acute versus chronic).
4. Uses a multimodal approach.

The plan should incorporate appropriate:

1. Non-pharmacological pain management strategies including:
    - Psychological approaches to pain management, including actively screening for underlying depression
    - Education and reconceptualisation of pain
    - Movement and exercise (where clinically appropriate)
    - Physical treatments that may include heat packs (care to avoid burns; most useful in acute pain), and modifying manual handling techniques to minimise pain
    - Complementary approaches
    - Attention to nutrition
    - Attention to resident's social needs
2. Pharmacological pain management strategies appropriate to the underlying cause of the pain, the type of pain and informed by the resident's comorbidities (e.g. impaired renal function).
    - Prescription of analgesia should include guidance on indications for administration (e.g. administer 1 hour prior to planned movement) and a plan for monitoring and review
    - Analgesic agents prescribed should be accompanied by instructions for monitoring and implementation of active strategies to minimise risk of potential side effects (see Table 2)
    - Simple analgesics prescribed regularly (e.g. paracetamol) are appropriate for mild pain and may be opioid sparing in moderate and severe pain; regular simple analgesia is particularly important in the cognitively impaired person with pain who may not request analgesia despite experiencing pain
    - Adjuvant agents may be helpful in chronic pain but caution is required in older persons due to related side effects; it is particularly important to consider the potential for anticholinergic side effects of adjuvant agents and balance these against a resident's cognitive reserve and falls risk. Use of adjuvant agents such as amitriptyline should be undertaken with extreme caution in the frail older person due to anticholinergic effects and associated increased risk of delirium and falls
    - Refer to Therapeutic Guidelines for specific recommendations of drugs and drug doses for pain management

Pain assessment and management practice points (cont'd)

5) Multidisciplinary pain management plan (cont'd)

Table 2: Strategies to minimise risk of potential side effects of analgesic agents
(note this table provides examples only and is not an exhaustive list of all risks in prescribing)

Analgesic	Risks	Risk management
Paracetamol	**Potential hepatic toxicity**	• Consider dose adjustment if < 50kg or in very frail persons – see QH guideline for safe paracetamol use
NSAIDs (best avoided in frail older persons - use with extreme caution and if used, then for defined, short time)	**Gastrointestinal bleed**	• Avoid in those who are on aspirin, anticoagulant agents and/or corticosteroids • Prescribe for limited short duration • Prefer COX-2 inhibitor agents • Co-prescribe with a PPI or proton-pump inhibitor • Monitor for abdominal pain, dark stools
	Renal dysfunction	• Avoid in those who are on concurrent ACE-inhibitor or ARB (angiotensin II receptor blocker) or who have prior renal dysfunction or hypoalbuminaemia • Avoid in those on concurrent loop diuretic • Monitor for impaired renal function, change in urine output, oedema or fatigue
Opioids	**Constipation**	• Commence bowel regimen to check for and prevent constipation • Tapentadol has less constipation risk compared to conventional opioids, and is less likely to cause excessive sedation and opioid-induced ventilatory impairment than other opioids
	Increased falls risk	• Opioids increase falls risk due to drowsiness, postural hypotension and hyponatremia • Start with low dose and escalate dose only if required and then slowly • Deprescribe (gradually lower dose) when clinical condition allows • All residents commenced on opioid medication should have institution of a falls risk management plan (or update of an existing plan)
	Opioid-induced ventilatory impairment (respiratory depression)	• Avoid concomitant administration of sedatives and simultaneous use of multiple opioid agents • Caution in renal impairment – use alternate agent or opioid that does not rely on renal excretion • Adjust dose relative to frailty • Monitor sedation using a sedation score as a score of 2 or more reliably predicts early opioid induced ventilatory impairment – the interval for monitoring should be informed by the route of opioid administration • All older persons prescribed opioids should be monitored using an individualised approach tailored to clinical need

Pain assessment and management practice points (cont'd)

6) Escalation criteria

Review the following escalation criteria in conjunction with Red Flag criteria and the residents goals of care which will inform the appropriate escalation process.

Escalation to an appropriate referral service (see pathway) should be considered, at GP discretion and in consultation with the resident and their nominated decision support person, if there is:

- Pain that continues to prevent sleep or wakes resident from sleep despite adequate analgesia
- Pain associated with significant weight loss
- Escalating analgesia requirements without a clear cause for pain
- Significant side effects from analgesia
- Ongoing distress of resident or family about escalating or unremitting pain

Pain assessment and management references

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Pain assessment and management version control

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