

# Pain Management

Pain is a universal human experience; however the perception and sensation of pain is unique to each individual. Pain may be treated as if considered the fifth vital sign. It is a complex combination of factors related to sensory, emotional, cognitive-evaluative, as well as interpersonal and cultural aspects. [14] Pain is a major reason for physician visits, hospitalizations, nursing home rehabilitation and placement, a significant reason for medication use (including unnecessary psychotropic medications), and an important concern for immobility, productivity, and quality of life. [15]

## **Initial Comprehensive Pain Assessments**

Multifaceted approaches and teamwork among healthcare providers can improve care by reducing unnecessary expenditures and complications by having a true focus on resident-centered care. [7] Medication changes upon hospital admission or discharge are a frequent cause of adverse events having the potential to cause moderate or severe discomfort and possible clinical deterioration. Medication substitutions can be the result of hospital formularies or needed changes in the route of administration (oral medication to intravenous or vice versa). Confusion by receiving caregivers or clinicians, and even with family members/representative or the resident themselves can cause complications with admissions or return to a post-acute care setting (e.g. nursing facility). This broken continuity is disproportionately seen in residents who are admitted to skilled nursing facilities from the hospital setting (particularly those individuals directly transferred into hospice care) without adequate narcotic pain relievers. [17]

## **Transition of care considerations (transfer of pain-related information)**

- Transition of care refers to either permanent or temporary movement of a resident when changes of condition occur. The resident is the ultimate authority regarding pain management. However in the nursing home setting, family members/representative or even the nursing home staff members may be the only advocates for a cognitively-impaired resident. These advocates may be the only individuals aware of how to effectively manage pain-related behavioral occurrences. Types of transfers include:
  - Transfers to different care locations (e.g. hospitals, other nursing homes, the community setting, etc.)
  - Transfers to different clinicians (e.g. changes in attending physician, emergency department staff, hospitalists, specialists, etc.)
  - Transfers of care within the same setting (e.g. general care to palliative or hospice, etc.) [17]
- Hospitals and nursing homes will be increasingly asking for individualized person-centered considerations on the resident's willingness or ability to self-report pain, or any potential aspects/barriers with communication pertaining to the resident. These considerations may include but are not limited to: language barriers, health literacy, cultural barriers, educational level, cognitive impairment, decision-making impairments, hearing/vision, the resident's former responses/side effects to pain relievers, pain-related body areas, and issues with ADL cares (bathing, dressing, feeding, etc.). This information can be vital in improving transitions to other care settings. [17]
  - Transitions of care need to be a smooth process. A process which incorporates the resident's treatment goals, preferences, as well as clinical status. Communication and information handover can be fundamental for encouraging continuity of care and coordination of care to promote safer and more satisfying transfers.

- An interdisciplinary process (including family members/representative input) is a necessity within the nursing home setting. However communication between locations (i.e. hospital to nursing home or vice versa) must be conducted with counterparts within the same discipline (MD to MD, nurse to nurse, or social worker to social worker, dietary to dietary, etc.). [17]

### **Pain assessment on admission to the nursing home setting**

A comprehensive pain assessment which is relevant to the individual's life history must be performed. Often times comprehensive pain assessments merely focus on current pain-related information within a short timeframe (i.e. just the last 5 days, or pain factors related to recent surgery).[13] With post-surgical procedure discharge to a nursing facility, older aches and pains may be overlooked. Whenever possible the resident themselves must be interviewed, although family members/representatives are also reliable sources for pain-related information. A review consists of:

- History of chronic conditions and body areas of concern, including all pain-related information: continuing aches/pains (arthritic areas or reoccurring illness), prior surgeries that still cause discomfort, any old injuries (car accidents, work-related trauma, or sports injuries), seasonal or episodic pain.
- Prior medication and non-drug interventions, cultural or religious considerations, problematic side effects, and medication attitudes: myths or beliefs.
- The goals of medication treatment and non-drug interventions (acceptable level of pain, quality of life and/or sleep considerations, and anticipated functional performance/independence).

### **Pain assessment on readmission to the nursing home setting**

Perform a new comprehensive pain assessment for pain-related factors or conditions which need to be addressed. This must include a review of previously recognized chronic pain-related conditions and prior pain management regimens. [13]

- Upon readmission back to the nursing home, the pain management regimen will need to be readdressed for appropriateness by the attending physician. Often times the hospital physician may be unaware of the severity of chronic pain-related conditions, and may have changed or discontinued routine orders when treating acute illnesses.
- Other practitioners (e.g., pain management specialists, neurologists, cancer specialists, etc.) may need to be contacted when drug regimens are changed upon readmission.
- The pain medication regimen must reflect the current pain-related condition with consideration of the resident's abilities, cognitive level, and structural difficulties in the nursing home. Example: the individual may have been discharged with a PRN dosage of pain reliever when a scheduled regimen may be more appropriate.

### **Pain Recognition**

Licensed nurses are responsible for evaluating and assessing pain. However as part of culture change, facility staff can review and update their policies, procedures, and current clinical practices for pain management. This update will need to include the supportive role of nursing assistants (CNAs and med aides) in identifying and reporting pain. CNA and med aide input must be valued not only for identifying pain, but also for their contribution in observing the effects of pain management therapies.

All nursing home staff members must be able to recognize the physical and behavioral expressions of pain and discomfort. All staff members must be able and willing to report pain to the attending nurses. Policies and procedures must reflect the implementation of a system which requires nursing assistants to regularly observe and describe any pain symptoms to the nurse and/or physician. Any pain symptoms reported must be followed up with an assessment by a licensed nurse utilizing a validated pain scale appropriate for the resident [4]. Staff members who feel that their reports are unacknowledged or unheard may become ineffective advocates for resident care. [2]

### **Barriers to effective pain management**

Unfortunately, barriers in the form of myths and misbeliefs may sometimes prevent residents from receiving adequate pain management. Physicians, staff, family members and even the resident themselves may at times avoid pain medications based on certain beliefs. Common beliefs that may pose a problem are: [4]

- Fear of addiction to pain medications
- Fear of regulatory oversight
- Fear of side effects/adverse reactions to pain medications

Breaking barriers to effect pain management must focus on addressing both staff and resident beliefs, as well as tackling systemic structural issues within the long-term care setting. An educational focus includes factors encompassing:

- Pain relief as a resident care priority (the staff may be desensitized, because pain is so common).
- Recognition, assessment, and ongoing evaluation with a periodic review of each staff member's responsibilities (important due to the likelihood of staff turnover).
- Correction of myths and mistaken beliefs. Staff members, residents, and family members may have inaccurate thoughts about pain medications and/or pain management therapies (drug and non-drug therapies).
- Proactive pain management for improving residents' quality of life (along with the added benefit of satisfaction for family members/representative and members of the staff).
- Understanding individual resident factors, such as physical or mental conditions and disease states that may contribute to unrecognized pain management.
  - The presence of chronic or long-standing mental illness (pain-related behaviors may be misconstrued or considered part of a psychiatric diagnosis).
  - Acute changes in condition that are pain-related may be viewed with shortsightedness. Medical personnel may not recognize the longer-term underlying discomfort, pain, aching, and soreness (e.g., pre- or post-wound care pain management, or inflammation/soreness in the days after a fall).

- Chronic conditions or disease states which cause stiffening or irregular movements may be seen as already treated or untreatable with regard to pain relief (e.g., Parkinson's disease, rheumatoid arthritis, or other conditions which cause dyskinesia, contractures, or muscle spasms, immobility, etc.).
- Individuals with polypharmacy (overburdened drug regimens) or individuals that require many medications who may be disregarded with pain management due to fear of adding an additional drug, or fear of additional side effects.
- Modifiable or treatable functional, physical, or sensory factors which may be overlooked may be contributing to or a risk factor for pain or discomfort (e.g., oral/dental considerations with choice of food/beverage, the need for repositioning due to cognitive impairment, etc.).

### **Considerations for those living with chronic pain or those having experienced recurrent pain**

Pain catastrophizing is a negative response to anticipated or actual pain. It is categorized as an exaggerated or excessive preoccupation with the pain experience. This preoccupation with pain is known to have multidimensional elements involving anxiety and depressive symptomatology. Individuals experiencing "catastrophic thinking" about pain can feel significant emotional distress, may become overwhelmed by their pain, or develop a sense of helplessness from the affect that pain is having on their lives. Individuals who experience pain catastrophizing may also have heightened pain intensity levels. Additionally, the emotional component of the individual's pain experience can contribute to the chronicity of the pain. [16]

- The three dimensions of pain catastrophizing include:
  - Rumination: "I can't stop thinking about how much it hurts"
  - Magnification: "I worry that something serious may happen"
  - Helplessness: "It's awful and I feel that it overwhelms me"

Catastrophizing incorporates features that are shared with depression, anxiety, and even elements of anger and hostility as well. Pain catastrophizing has also been associated with increased suicidal ideation in those with chronic pain-related conditions. [14]

Pain catastrophizing must be treated early on with cognitive behavioral therapy (CBT). The clinician/therapist must be mindful in developing coping strategies. Even in those individuals who do not engage in "catastrophic thinking", pain can control one's attention causing interference with mental processes and activities of daily living. "However, in persons who tend to catastrophize, pain might demand attention to the point of cognitive and behavioral immobilization." [14] Early interventions with suspected pain catastrophizing can lead to improved treatment outcomes for individuals and caregivers.

### **Cognitive impairment in pain management**

Pain recognition in those with moderate to severe cognitive impairment can be difficult to determine. Pain is considered an unmet need that is often challenging for residents with cognitive impairment to express. This inability to communicate pain can cause problems for an individual due to understanding and being understood by others. Possible barriers with communication in needed pain relief are: [1]

- Inability to use the appropriate words to describe pain
- Inability to express the presence of pain
- Inability to indicate the exact location of the pain

In an effort to communicate the need for pain relief, the outcome may result in behaviors. An interdisciplinary team approach is essential to investigate if pain may be the root cause of the behavioral disturbances, or if other unmet needs should be examined. Possible challenging behaviors that may occur related to pain are:

crying	pacing	agitation	irritability	sleeplessness
screaming	fidgeting	aggression	withdrawal	rocking/thrashing
swearing	restlessness	combativeness	refusal to eat	groaning/grunting

Pain or discomfort-related behaviors in residents with dementia may be misconstrued for psychiatric concerns leading to untreated or undertreated pain management. This may contribute to the initiation of unnecessary psychotropic medications. [2] For instance, the prevalence of aggression in individuals with dementia was estimated to be 30-50% [6]. Antipsychotic medications were often initiated at the onset of aggression even though pain may have been the underlying cause of the aggressive behavior [6]. Pain has been considered not only a predictive factor but also a treatable factor in association with aggression (verbal and/or physical aggression) [6]. Consequently, the initiation of an antipsychotic medication in the presence of unrecognized or undertreated pain may lead to further cognitive and functional decline, as well as exposure to unwanted side effects and risk factors. Also, symptoms of pain are often masked by antipsychotic and other psychotropic medications further leading to ineffective pain management.

- Steps toward pain recognition include:
  - Utilizing validated behavioral pain scales when assessing for the presence of pain.
  - The PACSLAC (pain assessment checklist for seniors with limited ability to communicate) tool in determining pain-related behaviors for individuals with cognitive impairment.
  - Using additional words and phrases besides asking “are you in pain”. It may be better for some residents to ask: “are you sore anywhere”, “do you ache anywhere”, “are you comfortable”, etc.
  - Understanding that for individuals with fluctuating cognition, a response of “no” may not always be reliable. Follow-up monitoring and assessments may be necessary if pain-related physical expressions or behaviors are present or suspected.
  
- The nursing home staff must watch for measures of physical well-being. [13]
  - Range of motion: tolerance for routine positions, mobility, and weight bearing
  - Level of activity: comfort level of usual tasks and action in the environment
  - Comfort with sleep and recognition of sleeping changes
  - Relaxation of the body: absence of tensing, favoring, limping, etc.
  - Comparison of noticeable improvement or lack of improvement with both drug therapies and non-drug therapies (including comfort measures)
  - Conversations or activities where less obvious discomfort words or behaviors are expressed (the necessity of staff members being able to “read between the lines”)
  
- Behaviors must be reviewed by an interdisciplinary team for underlying pain or discomfort
  - Physical and/or verbal aggression
  - Disruptive behaviors
  - Resisting care
  - Changes in appetite, sleep, or gait
  - Decreased function and involvement with ADLs, mobility, routines and activities
  - Increased depression, isolation, withdrawal, anxiety, restlessness, fidgeting

- Wandering or exit seeking behaviors
- Trends in behavioral occurrences need to be reviewed for time of day as an important indicator of a resident's recurrent pain or discomfort. Opportunities for proactive pain management or adjustments in a resident's current pain medication regimen may be gleaned from this review.
  - Morning stiffness
  - Afternoon/evening aches, numbness, soreness due to physical activity
  - Nighttime discomfort and pain (inability to fall asleep, middle of the night awakening, inability to stay asleep)

## **Treatment**

Pain medications are one intervention used to treat pain. Pain medications are commonly referred to as analgesics. Analgesic medications relieve mild to severe pain. Three groups that categorize analgesic medications exist for the intervention of pain: non-opioids, opioids, and adjuvant medications.

### **Non-opioid medications**

Acetaminophen is used to relieve pain of mild to moderate intensity. Acetaminophen is relatively safe when used within limited doses. The maximum daily dose for adults is 4000 mg per day, however for most geriatric individuals a maximum of 3000 mg per day is highly suggested [10]. In the presence of renal or hepatic insufficiency, acetaminophen should be administered with lower limits even less than 3000 mg per day. Acetaminophen use is not recommended for those with liver disease or alcohol consumption [10]. Acetaminophen may be useful for pain up to 7 on a 0/10 scale. However, it is not recommended to be used alone for treatment of severe pain [10].

Non-steroidal anti-inflammatory drugs (NSAIDs) are superior in efficacy over acetaminophen in conditions where inflammation is present. Due to the risk of cardiovascular, gastrointestinal, and renal effects, these medications are recommended to be used for a limited number of days (7 to 10 days.) [10]. Although there are some low dose or less potent NSAID's that may be prescribed for longer periods of time with proper monitoring, such as meloxicam, OTC naproxen or COX-2 inhibitors, longer acting non-steroidal medications such as piroxicam, oxaprozin and naproxen are generally not recommended in the elderly [10]. The potential benefit must be weighed over the risk with this drug class. Non-steroidal anti-inflammatory drugs are categorized into two groups: non-selective COX inhibitors (i.e. ibuprofen) and selective COX-2 inhibitors (i.e. celecoxib). These medications can cause complications which may lead to GI (gastrointestinal) bleeding, renal failure, high blood pressure and heart failure [10].

- Long time use of non-selective and selective COX-2 inhibitors may lead to cardiovascular complications (i.e. stroke, myocardial infarction). Cardiovascular risk factors include:
  - Age 65 and over
  - Male
  - Pre-existing cardiovascular disease
  - Existence of 3 or more cardiovascular risk factors
- GI bleeding may occur without warning, and at any time during NSAID medication use. The risk of GI bleeding doubles with concomitant use with aspirin as a cardio-protective agent [10]. Risk factors for GI bleeding include:
  - Female
  - Age 75 and over
  - History of GI bleeding episodes or cardiovascular complications

- Strategies to reduce the incidence of NSAID-induced GI bleeding usually include concomitant use of an NSAID with either:
  - H2 receptor antagonist
  - Misoprostol
  - Proton-pump inhibitor (PPIs)
    - However, caution must be exercised with the use of proton-pump inhibitors because of associated risk for osteoporosis, hypomagnesaemia, aspiration pneumonia, and C. difficile-associated diarrhea.
- Other strategies to reduce GI events suggest the use of a COX-2 inhibitor in the presence of low cardiovascular events. Also, the combination of a COX-2 inhibitor with a PPI may be beneficial as gastro protective in individuals with a high risk of bleeding

## Opioids

Opioid medications are used to treat acute and chronic pain of moderate to severe intensity. Pain associated with cancer-related conditions will respond to opioids. Opioids are also used in persistent non-cancer pain-related conditions, such as musculoskeletal disorders and neuropathic conditions. This group of medications must be used with caution in the elderly [10]. Although opioids may be used on a trial basis to reach a therapeutic goal in the elderly, these medications need to be titrated up to the most effective dose without incurring intolerable side effects [11]. Downward titration is accomplished with a gradual taper to prevent signs and symptoms of withdrawal. The advantage of opioids over non-opioid medications is that they do not cause end organ damage

The most common potential side effects of opioid pain medications are: [5]

respiratory depression	dizziness	nausea	pruritus
confusion	sedation	constipation	physical dependence

Morphine is considered the “gold standard” of opioid pain relievers [10]. The relative potency of other opioids is compared to the morphine-equivalent dose. Since pure opioid agonists have no ceiling dose effect, the dose can be titrating up until effective relief is obtained or side effects become a significant risk. Avoid morphine or use with caution in individuals with renal impairment; dosage may need to be adjusted.

### Barriers to Opioid Medications for Treatment:

- Barriers to adequate pain management with opioid treatment include a fear of addiction and intolerable side effects. This fear of addiction may deter the physician or individuals from seeking the optimal therapy for pain.
- In addition, nurses must become advocates to ensure that all residents receive adequate pain relief in spite of unsubstantiated beliefs about substance abuse. The American Society for Pain Management Nursing (ASPMN) and the International Nurses Society on Addictions (IntNSA) states that “patients with substance use disorders and pain have the right to be treated with dignity, respect, and the same quality of pain assessment and management as well as other patients.” [9]
- Physicians, staff, family members and residents must be educated on pain-related terminology and common misconceptions related to substance use disorders. Pain-related definitions include:

- Addiction: a neurobiological disease which is influenced by environmental, psychosocial, and genetic factors and is characterized by exhibiting one or more behaviors such as compulsive use, continued use and cravings despite harm, as well as impaired control over drug use [9].
  - Physical dependence: an expected physical response associated with certain drug classes that produce withdrawal symptoms specific to that drug class due to either sudden discontinuance of the drug, accelerated dose reduction, decrease blood levels of the drug and/or the administration of an antagonist medication. [9]
  - Pseudo-addiction: an iatrogenic syndrome associated with the under treatment of pain; characterized by various problematic behaviors that appear abuse-like. Pseudo-addiction is usually the result of undertreated pain, and can manifest as behaviors (i.e. anger, or demanding more medication) which may cause suspicion by staff and physicians. These behaviors are usually resolved when the pain is effectively treated [9].
  - Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time. [9]
- Appropriate monitoring parameters must be in place to ensure that an evaluation of response to treatment and the risk for inappropriate use of opioid pain medications in residents are occurring. Risk stratification is a system in which residents with pain are evaluated for the risk of developing a substance use disorder or diversion of controlled substances. [9]

Ethical obligations to ensure adequate pain control in all residents must include: [9]

- Assess and provide treatment for unrelieved pain.
  - Evaluate for any actual or potential risk of substance use disorder or addiction.
  - Use appropriate language when referring to residents with substance use disorders instead of using stigmatizing terms such as “drug seeking” or “junkie.”
  - Educate staff, family and physicians to correct any misconceptions regarding opioid pain medication use.
  - Advocate in providing alternate treatments in addition to opioid pain medications for residents with pain and substance use disorders.
- Misconceptions of substance use disorder can lead physicians, staff, family and residents to not attempt to use opioid pain medications even if the pain is undertreated. Education on correcting misconceptions must occur for all professional staff as well as the public. Therefore, a systematic approach must be developed to provide adequate pain management for individuals with substance use disorder. These guidelines should be included in a facility's policies and procedures. The ASPMN and IntNSA have recommendations for treating pain in individuals with addictive diseases. [9]
  - Individuals may avoid pursuing opioid pain medication treatment because they fear experiencing intolerable side effects. For instance, opioid medications are known to cause constipating effects which can cause additional discomfort and pain. Though individuals taking opioid analgesics develop a tolerance to most side effects after a few days, they may experience constipation during the course of treatment. Applying preventive measures in anticipation of unwanted symptoms can decrease the effect of intolerable side effects [10].

## **Tramadol**

Tramadol works as a centrally acting synthetic opioid analgesic. The parent drug (low-affinity) and its metabolite (high-affinity) bind to mu-opioid receptors and weakly inhibit the reuptake of serotonin and norepinephrine to relieve pain. [3] Tramadol can be considered for second-line therapy when acetaminophen or an NSAID is not effective. Tramadol can also be used for moderate to severe pain alone, or in combination with acetaminophen or an NSAID to work synergistically for pain relief [10].

Use Tramadol with caution when given in high doses or when other medications effecting serotonin levels are present in an individual's drug regimen. A rare disorder known as serotonin syndrome may occur.[10] Additionally tramadol administration, even within the recommended dosage range, can contribute to a lowering of the seizure threshold. Increased seizure risk is heightened with simultaneous use of serotonin reuptake inhibitors (SSRI antidepressants), tricyclic antidepressants (TCAs) or related compounds (e.g. cyclobenzaprine, promethazine, etc.), and some opioid analgesics. [3]

## **Adjuvant medications**

Adjuvant medications are drugs from different classes that reduce or alter the perception of pain via neuronal pathways by interfering with the pain signaling process. These drugs may include antidepressants, anticonvulsants and other drug classes.

Gabapentin and pregabalin are anticonvulsant medications proven to effectively treat most neuropathic conditions that produce pain by voltage ion channel blockade, altering the perception of pain. Gabapentin is FDA approved for post-herpetic neuralgia. Pregabalin is FDA approved for post-herpetic neuralgia, painful diabetic peripheral neuropathy, and fibromyalgia. [10].

Serotonin-norepinephrine reuptake inhibitors and tricyclics are antidepressant medications used in treating pain with neuropathies.

The World Health Organization has developed a strategic approach to treatment of cancer-related pain based upon pain intensity. The Pain Relief Ladder is based upon a 3 step process of incorporating analgesics from all three groups to provide pain relief [10] [5] [4].

- Step 1- Use a non-opioid or non-opioid plus adjuvant for mild pain
- Step 2-Use a weak opioid or weak opioid plus non-opioid or weak opioid plus adjuvant for mild to moderate pain
- Step 3-Use an opioid or opioid plus non-opioid or opioid plus adjuvant for moderate to severe pain

Increased pain intensity initiates a movement up to the next step. However, initial therapy in some individuals with severe pain may require the use of an opioid as a first-line drug therapy [10]. In the presence of moderate to severe pain, long-acting pain medications may be needed for effective pain control. Additionally, short-acting pain medications may be considered to assist in controlling breakthrough pain [5].

## **Non-pharmacological interventions**

Non-pharmacological interventions may be beneficial with mild pain, and in combination with pain medications. Distraction techniques and coping mechanisms are vital elements in the overall treatment of pain. Some examples include:

cognitive behavioral therapy (CBT)	interdisciplinary rehabilitation (PT/OT)	music therapy	massage
spirituality/prayer	exercise	relaxation therapy	art therapy/activities

For instance, music has been proven in several studies to be an effective tool to decrease the amount of analgesic medication [4]. However, music preference and volume control must be taken into consideration when initiating music therapy for residents.

### **Cultural and/or spiritual considerations**

Pain is more than a physiological or biochemical reaction to injury within the body. Pain responses also include emotional, social, and spiritual components that may be misunderstood by healthcare providers. When recognizing pain, caregivers must consider cultural and spiritual views within the context of the resident's beliefs and values. Cultural and spiritual components may influence: [8]

- the individual's perception and response to pain
- whether or not the individual will ask for pain medication
- whether individual's own healing practices take precedence over caregiver's recommendations

Language barriers and misinterpreted translations can further complicate cultural and spiritual concerns with pain management. Understanding a person's language is not necessarily the same as understanding a person's culture. Family members need to be involved with not only language translation, but with interpretations of the deeper meaning behind the communication. Having this involvement will promote better clinical outcomes. Inclusion of bilingual facility staff members can also improve more effective, timely, and appropriate treatments. However, there may be an increased likelihood of bilingual staff burnout. In an effort to reduce this concern, a facility will need to consider that the staff member's other duties can be compromised due to this time constraint. [18]

Some cultural influences include fatalism and stoicism. Some research has found that stoic behavior is more often found among Mexican Americans, American Indians, and Asian Americans. Healthcare providers may assume that pain does not exist, because the resident is not expressing it.

- Fatalism may influence pain management by imposing a belief that pain must be endured, and that it is necessary for spiritual growth. Pain may be seen as a test of one's fate/spiritual beliefs, or that pain is a punishment for past wrongdoings.
- Stoicism may lead to the reluctance of an individual to express pain either verbally or non-verbally. Stoic individuals may prefer to be left alone in order to bear their pain and suffering. Stoic responses may influence a person's willingness to self-report pain, and may lead to pain being underreported to healthcare providers.

Some Asians and Hispanics may associate a diagnosis of cancer as being close to death. With increasing pain, death is perceived to be nearby therefore furthering stoic behavior with a reluctance to acknowledge pain. Additionally, an individual may have thoughts that a life-threatening illness is either fate or karma, or that the illness is "God's will". [8]

“According to the Census Bureau (2008), the Hispanic population in the United States has reached 47 million people. This figure will almost triple to 133 million by 2050, when nearly one out of every three U.S. residents will be Hispanic...Approximately 40% of Hispanics in the U.S. were foreign-born as of 2000, compared to 60% of Hispanics who were born in the United States.” [18]

Traditional Hispanic cultural aspects may be imbedded in those who have emigrated<sup>8</sup> from Spanish-speaking countries. Some of the cultural aspects that may affect pain management include:  
[18]

- **Familismo:** Meaning family or extended family (i.e., neighbors and close friends) that are highly valued. Individuals can have a deep sense of commitment, obligation, and responsibility to the care of the collective family unit.
- **Machismo:** Meaning masculinity which does not hold a negative connotation. It reflects a traditional role where the man is the protector, main provider for the family, and primary decision maker. A Hispanic man's illness which affects his ability to provide for the family may have far reaching emotional or physical impacts cause him to feel shame and/or anger.
- **Marianismo:** Meaning the traditional role of the woman as being willing to self-sacrifice for the family (this is not a negative connotation). The role puts the husband and children first, even in the event of one's own illness. Women provide emotional, spiritual, and physical comfort for family members. Traditional women may present as being very modest and mindful of gender issues.
- **Personalismo:** Meaning personal relationships, refers to the concept that one must spend time understanding a person's history and interests first to gain trust and respect.
- **Respeto:** Meaning respect is the concept that elders and people of authority (i.e., religious leaders, physicians and other healthcare providers) are to be shown reverence. It may also be necessary to include heads of the family with decision making. Respect is a two-way street. If a traditional Hispanic individual is not shown respect, the effect may be a magnification of disrespect for the person showing a lack of respect. Another concept is that physicians are rarely questioned and are held second only to the position of a priest.
- **Fatalismo:** Meaning fatalism in the Hispanic culture refers to the belief that one's life is pre-determined, and that it is not possible to have control over health-related outcomes. Family members may be considered helpers of God, when aiding in recovery. Illness related pain may be seen as inevitable, and a person may decline treatments.
- **Confianza:** Meaning trust that is built between people over time. This concept establishes an interest in each other's lives and activities. Healthcare professionals who develop this type of trust will find improvement in a resident's willingness to accept treatments and improvement in the quality of caregiving services.

When cultural or spiritual considerations are suspected to have a strong impact on pain management, staff members need to respect the resident's choices. Although gaining insight into the person's beliefs can help caregivers to offer recommendations that coincide with the resident's philosophies. Staff members can consider asking probing questions to provide cultural insight into the meaning of the resident's pain. [8]

Kleinman's Assessment questions:

- What do you think caused the pain?
- Why do you think your pain started when it did?
- What do you think your pain does to you?

- How severe is your pain?
- What are the main problems your pain has caused you?
- What do you fear most about your pain?
- What kind of treatment do you think you should get?

#### The Explanatory Model Interview for Pain Assessment

- What do you call your pain? What name do you give it?
- Why do you think you have this pain?
- What does your pain mean to your body?
- How severe is it? Will it last a long or short time?
- Do you have any fears about your pain?
- If so, what do you fear most about your pain?
- What are the chief problems that your pain causes you?
- What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?
- What cultural remedies have you tried to help you with your pain?
- Have you seen a traditional healer for your pain? Do you want one?
- Who, if anyone, in your family do you talk to about your pain? What do they know? What do you want them to know?
- Do you have family and friends that help you because of your pain? Who helps you?

The inclusion of religious/spiritual practices into pain management techniques has shown the result of lowering pain ratings, more positive pain attitudes, and a greater acceptance of pain medication. [8]

### **Analgesic administration for those with cognitive impairment**

Timing of medication administration is extremely important in providing adequate pain relief [10]. As needed pain medications with a rapid onset/short duration can be administered for breakthrough and anticipated pain episodes [10] [11]. However, as-needed scheduling is usually not recommended for residents with cognitive impairment due to their inability or unreliability in requesting pain medications [11]. Therefore, pain medications are more effective when scheduled routinely for anticipated pain episodes in this population [11]. For individuals experiencing continuous pain, around the clock (ATC) analgesic administration must be considered [11].

Pain can be difficult to determine in those individuals with moderate to severe cognitive impairment. This could be due to problems with understanding their individual care needs. Residents with this level of impairment may not be able to effectively communicate discomfort or pain. Failure to communicate those needs may lead to agitated behaviors, negative receptiveness to care, staff misconceptions and frustrations, and possibly avoidable hospitalizations or re-hospitalizations. Therefore, a systematic approach to detect and treat pain in individuals with moderate to severe cognitive impairment with the inability to effectively and reliably communicate pain must be implemented.

- The Serial Trial Intervention (STI) is a proactive systemic process to assess and treat pain in individuals with moderate to severe cognitive impairment. The STI studies suggest that some dementia-related behaviors have a strong relation to an individual's level of comfort. The Serial Trial Intervention demonstrates an overall diminishing of dementia's negative effects such as: discomfort, agitation, problematic vocalizations, comorbid conditions, acute hospital visits, and resistance to care. [5] When challenging behavior(s) are identified, the following systematic steps are recommended:[12]

1. Physical needs assessment and subsequent approaches as indicated.
  2. An effective needs assessment and subsequent approaches as indicated.
  3. A trial of non-pharmacologic comfort treatment(s) tailored to the individual.
  4. A trial of analgesic agents for pain treatment.
  5. Consultation with other disciplines
  6. Scheduled dosing of effective (analgesic and non-drug) treatments for continued use if one time treatment is effective.
  7. Stop ineffective treatments (based on daily tracking forms)
  8. Add adjunctive and preventative treatments.
  9. Monitor for recurrence and new problems.
- Empirical trials, prior assessments, history of treatments (i.e. failed or successful) and estimated pain intensity using observational pain scales such as the PACSLAC or PAINAD (Pain Assessment in Advanced Dementia) must be taken into consideration in determining the appropriate drug interventions [4].
  - In individuals with mild to moderate pain, non-opioid medications such as acetaminophen may be beneficial. If this drug intervention improves behavioral disturbances, continue the initial therapy with added non-pharmacological interventions.
  - If behavioral disturbances are unchanged, a low dose of a short-acting opioid medication may be used. Also, consider increasing the dose by 25 to 50% if no change is observed in 24 hours. Titration may occur until behavioral disturbances subside or intolerable side effects occur.
  - If behavioral disturbances continue after a reasonable trial dose of pain medications, seek other possible causes.

## **Monitoring**

The consequences of untreated pain or discomfort can have an effect on other underlying conditions such as increased morbidity or mortality, sleep disturbances, decreased socialization, malnutrition, depression, impaired immune function, impaired mobility, increased healthcare utilization and cost, as well as cognitive, social, and functional declines.

- Pain may be more severe for an individual at different times during the day and may warrant more persistent monitoring.
  - More frequent brief pain evaluations, by scoring for level of pain using an appropriate pain scale, which may need to be targeted (even scheduled on the Medication Administration Record) to individualize optimal pain management effectiveness.
  - If there are long stretches in between medication dosages, mid-range pain evaluations need to be considered until pain relief is observed.
- Personal preferences of cognitively intact individuals need to be honored.
  - Some individuals may choose control of pain medication therapy with PRNs preferred over scheduled treatment. Documentation of this preference is included on quarterly assessments and with the care plan. The nursing staff will need to readdress this choice at least quarterly to make certain that “PRN only” is still the individual’s preference.
  - For mild pain, some individuals may prefer “topical only” drug treatments. Topical only treatments need to be addressed quarterly to make sure this is still the individual’s preference, or if adjunct medication therapy is a new consideration.
  - Due to personal preference or cultural/spiritual considerations, some individuals may elect to accept “non-pharmacological interventions only”. The facility must respect the

person's wishes and care plan those wishes. Continued monitoring for level of pain, and continued quarterly pain assessments must still be documented in the clinical record.

- Ongoing review of the pain management system (pain flow sheets and paper MAR, or the e-MAR system) must occur for every resident. If PRN treatments are frequent or trending at specific times during the day, this must be addressed with the resident (when possible) and the attending physician for considerations of more effective scheduled pain management.
- Quarterly pain assessments need to focus on pain management effectiveness from quarter to quarter (not just pain recognized over a short period of time).
  - Chronic and acute pain-related conditions/behaviors that happened within the quarter need to be reviewed for considerations in altering the resident's pain medication regimen.
    - Review the scale(s) used by the staff (are they appropriate for the individuals current cognitive and functional abilities).
    - Review the actual scores documented: is the pre-administration intensity increasing or is the post-administration score still showing discomfort.
    - If there is high pain rating scores, the pain regimen may need adjustments for the frequency of the dose, the drug strength, or the drug itself may need to be changed.
    - Review the body areas reported (any new, reoccurring, or changing pain areas).
    - Review the times of day when medications are given (there may be opportunity to discuss changes in the drug regimen).
  - CNA or med aide documentation or reported observations must be reviewed.
    - Check the point-of-care system for CNA documentation of pain or the ADL flow sheets for "yes" or "no" pain observations.
    - The MAR may contain a listing for med aide documentation of the resident's self-report for "yes" or "no" pain observations.
  - Review other reports where other disciplines have documented observed pain.
    - Physical therapy: resident self-reports of pain at rest or with movement, or range of motion difficulties.
    - Occupational therapy: resident self-reports of pain interfering with function.
    - Behavioral and/or psychiatric therapy: resident self-reports of pain or increasing depression/anxiety which may be related to ineffective pain management.

### **Monitoring the effectiveness of the facility's pain management systems**

Quality improvement is an ongoing necessity in the nursing home setting. When the facility's Quality Measures for pain (short stay and long stay) are out of line with the state and/or national averages, a systems review must take place. Additionally, ineffective pain management policies and procedures may affect many other care areas and can affect a facility's overall Quality Measures.

- Review the facility's current Quality Measures pain percentages. If the short-stay and/or long-stay measures are above the national average, quality improvement may be needed or the current system may need to be reviewed for potential changes.
- A facility's MDS coordinator has the responsibility of reporting changes in pain levels to the direct care staff. Increased monitoring of a resident's pain management regimen may be necessary.

- Residents or family members/representatives may initiate more complaints when ineffective pain management practices are present in a facility.
- Residents with untreated or undertreated pain may place greater burdens on the staff.
  - Individuals may be harder to care for with more frustrations or behaviors with ADLs.
  - Individuals may be more dependent on the staff overall due to lack of mobility.
  - Individuals may require more than one assistant with care, and may require more lifting.
  - Individuals can be more irritable, and unwilling to participate with therapies or activities.

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