

Assessing Pain in the Elderly

Course ID: 1026 - Credit Hours: 1

Author(s)

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Disclosures

None.

Audience

RN, LVN/LPN

Accreditation

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Course Objectives

Upon completion of this course participants should be able to:

1. List 3 barriers to recognizing pain.
2. Define pain.
3. Describe multiple pain scales.
4. List 5 methods for assessing pain.

Recognizing Pain

- The # 1 reason for failure to treat pain in LTC is the failure to detect it.

Resident related barriers

- Misconception that pain is a normal part of aging
- Belief that suffering is punishment for past actions
- Fear that pain means new or worsening disease
- Concerns about not being a “good patient”

Resident related barriers

- Fear of addiction or being thought of as an addict
- Worries about unmanageable side effects
- Language and cultural barriers and beliefs

Communication Barriers

- C.N.A. reports are often ignored, not included in shift reports
- Nurse does not ask if the resident is having pain, so few PRN medications are given
- Shift-to-shift conflicts about the treatment plan, based on own personal beliefs
- Nurse to physician incomplete information, non-specific requests
- Nurse assessment of pain, verbal and non-verbal in incomplete or insufficient

What is Pain?

- “Pain is whatever the experiencing person say it is and it exists whenever he/she says it does”



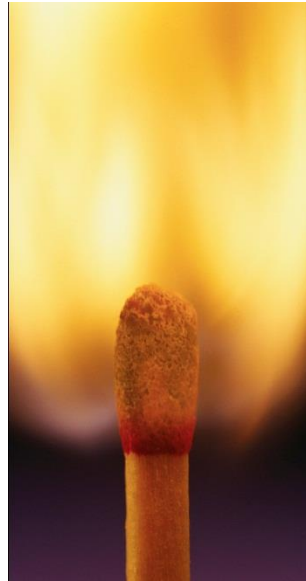
Pain screening interviews

- Do you feel pain anywhere right now?
- Does pain stop you from doing things you enjoy?
- Does pain keep from sleeping at night?
- Do you have pain everyday?



Descriptors of pain

- Agonizing
- Aching
- Abrupt
- Burning
- Constant
- Crushing
- Cramping



- Dull
- Excruciating
- Hot
- Heavy
- Intermittent
- Pinching
- Prickly



Descriptors of pain

- Nauseating
- Pressure
- Sharp
- Sore
- Sudden
- Stabbing
- Sickening
- Shooting
- Tingling
- Tender
- Takes breath away
- Throbbing
- Unbearable



Pain rating scale

Wong-Baker FACES Pain Rating Scale

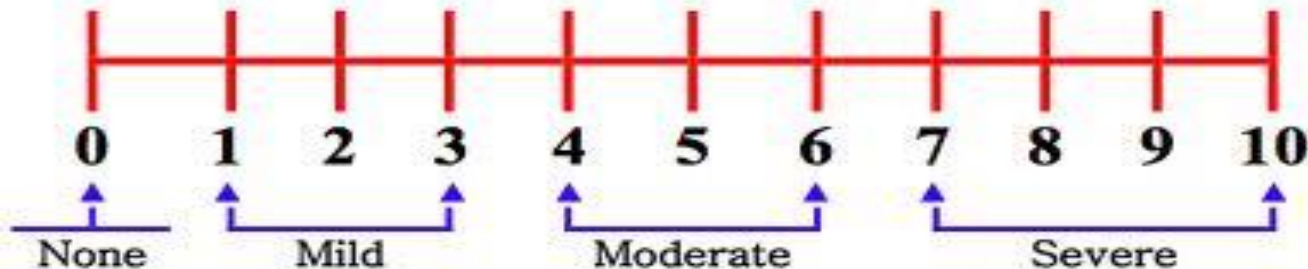
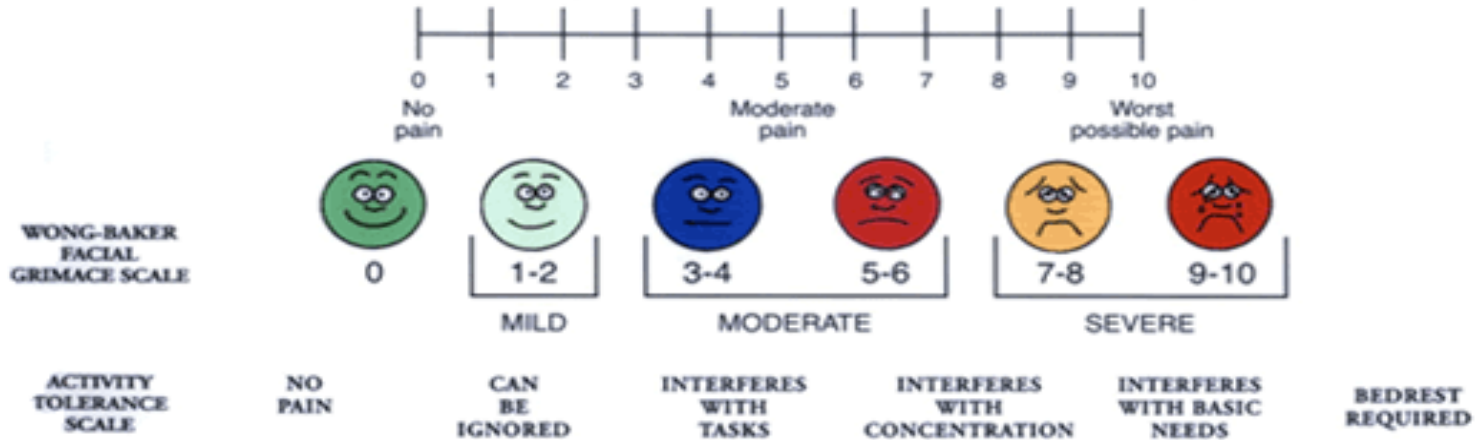


From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Numeric pain scale

UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.



Pain Assessment IN Advanced Dementia

PAINAD

	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

This material prepared by the Geriatric Research Education Clinical Center, is provided by the Iowa Foundation for Medical Care, the Medicare Quality Improvement Organization for Iowa, was prepared by MetaStar, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

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Assessing pain

- Many residents have more than one source of pain so may require more than one approach to pain management.
- If pain is identified upon a screening, then a comprehensive pain assessment should be completed.

Pain screening Timing

- ✓ Each time vital signs are taken
- ✓ Each time a treatment is performed
- ✓ Each time pain medication is given (routine or PRN)
- ✓ Each time an invasive procedure is performed
- ✓ Anytime a resident has a non-verbal or verbal sign of pain
- ✓ With any change of condition
- ✓ With any admission or re-admission
- ✓ With any adverse change in behavior



Pain screen Documentation

Document

- ✓ On the back of the MAR
- ✓ On the back of the TAR
- ✓ On the 24 hour shift to shift report
- ✓ In the nurses notes
- ✓ On the vital signs flow record
- ✓ On the monthly summary
- ✓ On the skilled nurses notes
- ✓ On interdisciplinary notes



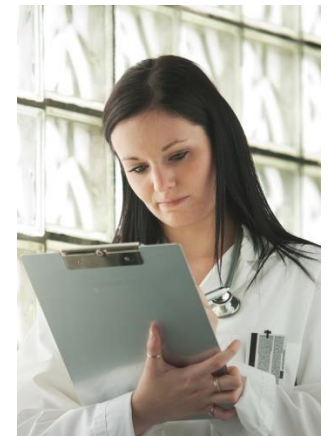
Type of pain scale

- When screening for pain it is necessary to document the type of pain scale used and to use the same pain scale consistently.



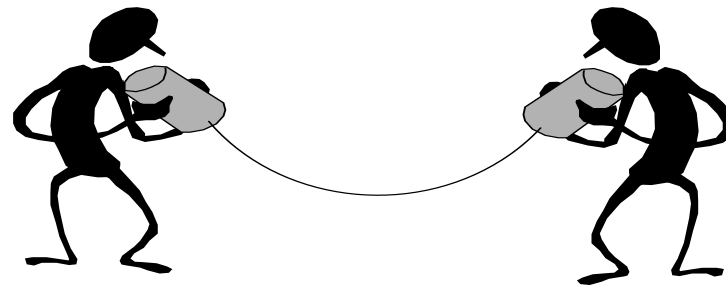
Comprehensive Pain assessment

- ✓ Regular intervals for all residents
- ✓ With any new complaint or sign of pain
- ✓ With any increase in pain or
- ✓ With any sign or report of unrelieved pain
- ✓ With any fall incident
- ✓ With new admissions
- ✓ With re-admissions
- ✓ With any change of condition



Communicate!

- Tell the physician
- Tell the resident
- Tell the family
- Tell your co-workers
- ✓ Recognize the pain
- ✓ Treat the pain
- ✓ Evaluate the treatment
- ✓ Revise the pain plan



Re-assess

- At regular intervals
- With any complaint of increasing pain
- Following any change of condition
- With changes in behavior
- With decreased physical functioning

