Resident Centered Pain Care
Pain Protocol

This protocol is a flexible guideline to use in the treatment of pain. It is a reference tool and not intended to be rigid criteria.

Identifying Residents with Pain
Residents are routinely reviewed for verbal and nonverbal signs and symptoms of pain. Review occurs within 24 hours of admission, before every MDS and as needed.

Assessment of Pain
Residents who show evidence of pain are thoroughly assessed including physical, emotional and spiritual components to determine cause and the most appropriate intervention.

Assessment of the Cognitively Impaired Resident
Residents who are nonverbal or who have severe cognitive impairment are assessed for behaviors that could indicate pain and conditions that could caused pain. If conditions and behaviors exist, it is necessary to rule out pain. When behaviors are unchanged after possible causes are eliminated and/or trial of appropriate medication and complementary intervention, it can be concluded the behaviors are not related to pain.

Intensity of Pain
When possible, the intensity of pain is rated on a 1-10 scale. 1-3 indicates mild pain, 4-6 moderate (interferes with work or sleep) and 7-10 severe pain (interferes with all activities). Residents who report an intensity of pain inconsistent with their level of functioning receive further assessment and education about rating pain. For residents who cannot verbalize pain intensity, the goal is to identify individual and unique behaviors that indicate pain and pain intensity. Care is taken not to simply equate behavior scales with pain intensity scales.

Care Planning for Pain
Every resident care plan includes pain or the potential for pain.
The individual goals for pain management are determined by the resident in collaboration with the interdisciplinary team. Goals are formulated to achieve the resident's desired balanced between function vs. absence of pain.

Treatment includes resident and family education with a goal of addressing myths and fears and enabling a sense of control and collaboration with the interdisciplinary team.
Interventions for pain are individualized for each resident and include both drug and non-drug approaches. Residents receive education about their role in managing their pain.
All medications and treatments are monitored for effects and possible side effects. The frequency of monitoring and reassessment varies with the medication. New medications, especially opioids are closely monitored.

Education of Residents and Families
Residents and their families receive education about pain on admission, during care conferences and as needed to promote effective pain management. This education includes:

- the importance of effective pain management
- how to seek help for pain
- how to follow-up if pain goals are not met
- how to use a standardized pain scale (0-10), verbal or non-verbal, for the assessment of discomfort
- pain relief measures including medication and alternative methods
- the resident's right to refuse pain treatment

Report of Pain
The resident's report of pain is accepted. Residents are promised a quick response to pain. Severe pain is responded to in an urgent manner.

WHO Ladder
Pain medications are prescribed and administered using the World Health Organization (WHO) analgesic ladder as a guide.
The basic concepts of WHO ladder are "by the clock, by the mouth and by the ladder." See attachment.

By the Clock:
Residents who have persistent pain are treated with routinely scheduled analgesics and "prn" doses for breakthrough or incident pain. Short acting medications are used when pain is exacerbating and long acting when pain has stabilized for around the clock dosing. For chronic moderate or severe pain a long acting medication is given around the clock. Breakthrough or

“prn” doses are equal to 10-15% of the 24 hour dose and are ordered every 1 hour as needed.
Circumstances that can cause pain are identified and interventions to prevent or reduce pain are initiated before pain occurs.

By the Mouth:
Medications are administered orally when possible. Medications are administered by the least invasive and most convenient route available.

By the Ladder
A non-opioid (acetaminophen) is used for mild pain, then if necessary mild opioids are added for moderate pain. . Strong opioids are indicated for severe pain. If pain is severe at the outset, strong opioids can be used.
Adjuvant medications can be used in addition or alone at each step of the ladder according to individual needs.
Neuropathic pain is treated with antidepressants, anticonvulsants, anti-epilepsy and/or anesthetic patches. Opioids can also be effective in the treatment of neuropathic pain

Equianalgesia
Equianalgesic charts are used when switching from one opioid to another. The dose is decreased by 1/3 if pain is controlled in consideration of incomplete cross-tolerance. If pain is not controlled the dose of the new medication can be equal or increased.

Side Effects & Adverse Effects
Residents who are treated with opioids also have a scheduled bowel regime to prevent constipation. A stimulant laxative is recommended. A bowel regime is initiated when the opioid is prescribed, not waiting for constipation to occur.
The risk of GI bleeding and renal impairment with NSAIDs in the elderly is recognized. NSAIDs are generally not used or used with caution following the December 2008 American Geriatric Society recommendations for older persons with persistent pain.
Care is taken with acetominophen and combination medications to not exceed recommended ceiling doses.
The risk of respiratory depression with opioids is recognized and opioid doses are carefully titrated to minimize this risk.
Propoxyphene (Darvon) and meperidine(Demerol) are avoided.
Difficult cases are referred for appropriate consultation.

Care is exercised with all pain medications recognizing the potential for serious side effects or even death. It is recognized that each individual responds differently to pain and that the elderly usually require lower starting doses. The mantra “start low, go slow” is followed.

Non-drug Interventions

The care plan of the resident with pain includes interdisciplinary non-pharmacological interventions. These interventions are determined based on what comforts and is acceptable to the resident.

Non-pharmacological interventions can include but are not limited to:

Cognitive-Behavioral- education, imagery, relaxation, music, distraction, meditation, prayer, art therapy, hypnosis, psychotherapy, support groups, humor, laughter.

Physical – Exercise, physical therapy, occupational therapy, massage, acupuncture, heat, cold, repositioning, immobilization, splints, yoga, chiropractics, and TENS.

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