PAIN ASSESSMENT CARE GUIDE

Pain is an individual, multifactorial experience influenced by culture, previous pain events, and ability to cope.
Pain is what the person says it is.

"Tell me about your pain"
Is this pain increased or on-going?

ALERT
If acute chest pain contact GP refer page 8 RN Care Guides

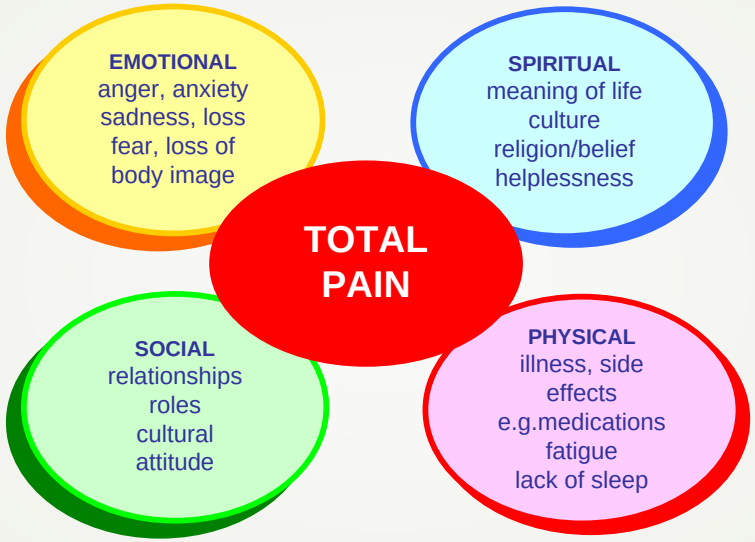
Does the resident have communications problem eg advanced dementia, impaired, non verbal?

YES

Use the Abbey Pain Scale or Painad

Dementia or non verbal residents

- **Vocalisation:** whimpering, groaning, crying
- **Facial expression:** looking tense, frowning, grimacing or looking frightened
- **Change in body language:** fidgeting, rocking, guarding part of the body, withdrawn
- **Behavioural change:** increased confusion, refusing to eat, alteration in usual patterns
- **Physiological change:** temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
- **Physical changes:** skin tears, pressure areas, arthritis, contractures, previous injuries



REMEMBER

- People may have more than one pain over multiple sites
- People use different words to describe pain
- Identify and treat reversible causes of pain e.g. UTI, constipation, trauma
- Listen to care givers and families
- Document in progress notes
- Making and then following an individualized care plan
- Re assess regularly
- Discuss with GP

NO

P Provokes – what makes the pain better or worse?

Q Quality – what does it feel like? Is it sharp, dull, stabbing, burning, crushing?

R Radiation – does the pain radiate, move anywhere?

S Severity – how bad is the pain, how severe is it?

T Time – when does it occur, how long does it last?

What does the resident think is causing the pain?

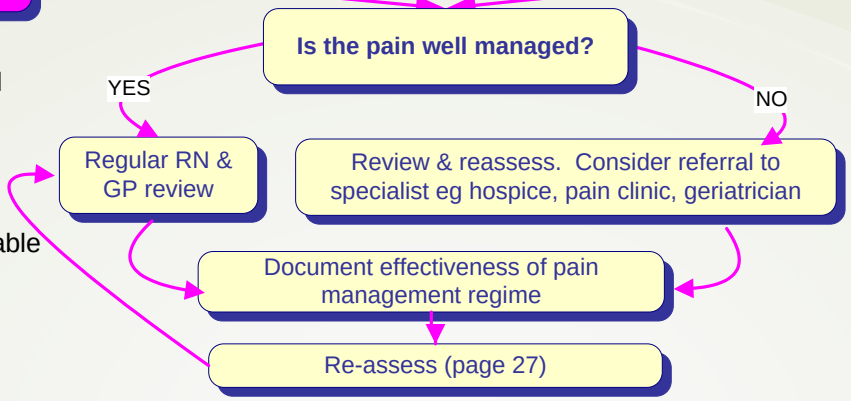
PAIN MANAGEMENT CARE GUIDE

Successful pain management is:

- Is the resident centred and realistic?
- Involves the resident and their families
- Is built on accurate pain assessment
- Uses a holistic approach

NON PHARMACOLOGICAL APPROACHES

- Supportive talk
- Gentle touch
- Distraction
- Repositioning
- Appropriate activities
- Complimentary therapies eg massage, aromatherapy, relaxation or Rongoa
- Music
- Pressure relief
- Prayer & spiritual support
- Listening
- Reminiscing
- Heat / cold
- Encourage & enable family/cultural involvement & support
- Rest



PHARMACOLOGICAL APPROACHES

- "Right drug for pain type"
- Review previous pain management
- Start low and go slow
- Review affect
- Consider & treat side effects e.g. constipation, nausea & vomiting

"Right drug for right pain"	Nociceptive		Neuropathic
	Somatic	Visceral	
Tips	Consider risk factors of treatment e.g. advanced age, renal and hepatic clearance, cardiovascular disease, gastro-oesophageal disease, glucocorticoid use.		**Establish diagnosis where possible:** some specific causes have preferred therapy e.g. carbamazepine for trigeminal neuralgia.
Examples	**Superficial:** skin, mucosa Deep: bones, organ capsules, lymph nodes	Organs, deep tumour masses, deep lymph nodes	Shingles, painful peripheral neuropathy, phantom pain, sciatica
Descriptors	Ache, throbbing, dull	Dull deep cramping, colicky, pressure	Pins and needles, burning, shooting
Stepped approach	**Topical agent** e.g. capsaicin		**Topical agent** e.g. capsaicin, aspirin in chloroform
	Paracetamol: no more than 1g QID: consider risk for hepatoxicity		**Tricyclic antidepressants:** Can have multiple anti cholinergic side effects e.g. dry mouth, orthostatic hypotension, constipation, urinary retention, sedation. Contraindicated in some patients e.g. cardiac conduction disturbances. **Serotonin norepinephrine reuptake inhibitors:** Consider risk for cardiac conduction abnormalities. Common side effects include nausea, dry mouth, constipation, insomnia, drowsiness. **Calcium channel alpha 2-delta ligands:** e.g. gabapentin. Consider low dose dependent dizziness and sedation.
	Opioids: e.g. oxycodone, morphine (codeine not generally recommended because of low potency and high potential for constipation). Long term use for chronic non-malignant pain with moderate to severe pain that affects function and/or quality of life. *Proactive prescribing to manage common side effects: nausea and vomiting, constipation.*		**Opioids:** e.g. oxycodone, morphine. Add as second line agent. Most patients require combination therapy. Less than half of patients with neuropathic pain respond to a single agent. Proactive prescribing to manage common side effects: nausea and vomiting, constipation.

START LOW & GO SLOW

Comments: *Non steroidal anti-inflammatories are not recommended and should be used with great caution and only if the patient is free of heart failure, GI disease, asthma or renal impairment. Strongly consider using a proton pump inhibitor. Monitor for fluid retention deterioration of renal function. Cox-2 inhibitors offer no advantage over traditional agents in persons on aspirin.* *See page 31 Medicine Care Guides for more detail.* *Interaction potential with antihypertensives, warfarin, aspirin.*

Refer to pain specialist if pain not adequately managed