**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?

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

**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- **Change in body language:** fidgeting, rocking, guarding part of the body, withdrawn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

**EMOTIONAL**
anger, anxiety, sadness, loss fear, loss of body image

**SPRITUAL**
meaning of life, culture, religion/belief, helplessness

**SOCIAL**
relationships, roles, cultural attitude

**PHYSICAL**
illness, side effects, e.g. medications, fatigue, lack of sleep

**TOTAL PAIN**

**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

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

**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?
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

**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

<table>
<thead>
<tr>
<th>“Right drug for right pain”</th>
<th>Nociceptive</th>
<th>Visceral</th>
<th>Neuropathic</th>
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</thead>
<tbody>
<tr>
<td><strong>Tips</strong></td>
<td>Somatic</td>
<td>Visceral</td>
<td>Neuropathic</td>
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<td>Organ, deep tumour masses, deep lymph nodes</td>
<td>Establish diagnosis where possible: some specific causes have preferred therapy e.g. carbamazepine for trigeminal neuralgia.</td>
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<td><strong>Examples</strong></td>
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<td>Superficial: skin, mucosa</td>
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<td>Shingles, painful peripheral neuropathy, phantom pain, sciatica</td>
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<td>Deep: bones, organ capsules, lymph nodes</td>
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<td>Pins and needles, burning, shooting</td>
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<td><strong>Descriptors</strong></td>
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<td>Ache, throbbing, dull</td>
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<td>Dull deep cramping, colicky, pressure</td>
<td>Topical agent e.g. capsaicin, aspirin in chloroform</td>
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<td><strong>Stepped approach</strong></td>
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<td>Topical agent e.g. capsaicin</td>
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<td>Tricyclic antidepressants:</td>
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<td>Paracetamol: no more than 1g QID: consider risk for hepatotoxicity</td>
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<td>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.</td>
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<td>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.</td>
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<td>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.</td>
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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