

Stroke Education series

Putting Best Practices into Practice: Caring for residents with Stroke

Part 2 - Minimizing and Managing Pain for residents with Stroke

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Putting Best Practices into Practice: Caring for residents with Stroke

A collaboration by RNAO LTC Best Practice program and Central South Regional Stroke Network.

This is part two of the four part Stroke Education series to support LTC staff to:

1. Assess pain for residents with Stroke.
2. Understand the relationship between pain assessment and management, fall prevention and management, reducing and supporting behaviors, and preventing pressure injuries in residents with Stroke.
3. Discuss the importance of an inter-professional team approach in Stroke Care.
4. Understand how to Integrate evidence-based resources in planning and improving care for residents with Stroke.

Stroke and Long Term Care

Of every 100 people who have had a stroke:

- 15 die
- 10 recover completely
- 21.3% of residents in LTC have had a stroke (CIHI 2014-15)
- Each year approximately 13,000 Ontarians are discharged from hospital following a stroke or TIA
- 1411 stroke persons were admitted to long term care homes within 6 months of an acute stroke in Ontario in 2014-15 (Ontario Stroke Evaluation: Report 2018: Stroke Quality of Care and Outcomes in LTC)
- Stroke is the third most common diagnosis in long term care (Price Waterhouse Cooper 2001)

Stroke and Long Term Care

Communication:

- 44.3% of stroke persons were understood (625/1411)
- 35.1% usually understood (495/1411)
 - Total: 79.4%
- 15.5% sometimes understood (218/1411)
- 5.2% rarely understood (73/1411)

Cognition:

- 20.3% of the stroke persons in long term care had severe cognitive impairment

(Ontario Stroke Evaluation Report 2018: Stroke Quality of Care and Outcomes in LTC)

Stroke in Long Term Care

Pain:

- 10.5% of stroke residents experience pain daily

Falls:

- 25.5% of stroke residents fall

Aggressive (Responsive) Behaviour:

- 29.8% (421/1411) are considered aggressive
- 4.9% (69/1411) are considered severely aggressive

Continence:

- 27.1% (383/1411) bladder continent 61.3% bladder incontinent
- 47.3% (667/1411) bowel continent 45.4% bowel incontinent

(Ontario Stroke Evaluation Report 2018: Stroke quality of Care and Outcomes in LTC)

**Pain is such an uncomfortable feeling
that even a tiny amount of it
is enough to ruin every enjoyment**

Will Rogers

Pain

- Pain is a sensation in the body that causes discomfort and can negatively affect mood and stroke recovery
- Pain is either acute or chronic.
- Chronic pain may arise from an initial stroke and its impact on the body or there may be an ongoing cause that is persistent. Usually lasts more than 3-6 months.
- Described in many ways: sharp, dull, aching, shooting, burning, cutting, numbing, stabbing
- Pain may be present even in body parts with impaired movement or sensation
- People with dementia or cognitive impairment experience pain
- Stroke residents in LTC : - 1 of 2 has ongoing and frequent pain
 - 1 of 4 has daily pain
 - 7 of 10 have untreated pain

Pain

- Pain has been described by Hicks as “a highly individualized unpleasant experience involving all aspects of the person, amenable to intervention, yet when left unattended, resulting in decreased overall quality of life” (Cowan et.al.,2003:292)
- The effects of untreated or under-treated pain may have undesirable physical and psychological consequences, with evidence to suggest that improved pain relief contributes to a person being able to engage in their physical and mental activity
- There are many interrelated problems caused by inadequate pain treatment in elderly residents in LTC: impaired mobility, posture, appetite, memory, decreased socialization, sleep disturbance, and depression. Problems with bowel and bladder functions and impaired dressing and grooming

**Pain after stroke is a symptom often forgotten,
unnoticed although it is reported
to be a great problem in care**

Widar M, Alstrom G. disability after stroke and the influence of long-term pain on everyday left.

Scand J Caring Sci 2002;16:302-310

Types of Stroke Pain

There are 3 main types of pain that can result from a stroke:

1. Shoulder Pain
2. Stiffness and Tightness of Muscles
3. Nerve Pain

Shoulder Pain – Subluxed Shoulder

- Up to 72% of stroke persons have shoulder pain
- Occurs on the affected side within a few days, weeks or months post stroke
- Due to little or no voluntary movement of the upper limb
- Resulting in prolonged stiffness, loss of movement and often severe pain
- Early supportive positioning and correct handling can prevent shoulder pain.
- Shoulder joint muscles become weak with low tone due to insufficient stimulation from the brain resulting in shoulder becoming loose and poorly aligned or partially dislocated (subluxed)
- Subluxation may cause soft tissue pain
- Pain described as “toothache type” – constant, dull and diffuse
- PROM can jam the ball into the socket and result in sharp severe pain localized at joint front and damage tissues around the shoulder and arm
- Consult with PT, OT or Physician

Stiffness and Tightness of Muscles

- Unused or partially used shoulder muscles can become stiff and tight creating pain when there is movement of the limb due to the restriction of tight and stiff muscles
- 5 key strategies to minimize pain:
 1. Support the affected arm at all times
 2. Do not perform PROM on the limb unless trained
 3. Never pull on a limb during transfer, positioning or ambulation
 4. Pay attention to supported positioning and good alignment
 5. Be careful

Nerve Pain

- Central post-stroke pain (CPSP) describes a neuropathic pain syndrome following a stroke
- Characterized by pain and sensory abnormalities in body parts affected by the stroke
- Pain is described as burning, aching, prickling, cutting, piercing or stabbing. Numbness or cold increases the pain

Pain Behaviours

- Stroke residents would demonstrate pain:
 - Through use of words – “that hurts”, “ouch”, “stop that”
 - cursing
 - burning, throbbing, stabbing
 - Action of rubbing affected area
 - Pain noises – moans, groans, cries, gasps, sighs
 - Bracing – rigidity, holding, guarding (especially during movement) frequent shifting
 - Pain Faces – furrowed brow, grimaces, winces
 - Restlessness – rocking, inability to settle
 - Changes from typical behavior – poor appetite, depressive symptoms, sleep issues, functional change
 - Follow up on reported pain – ask more about it and don’t forget and tell team members
 - use y/n questions, use simple words and the word “pain” or point to
 - be patient and provide time for them to explain their pain due to stroke deficits
 - Dementia people experience pain
 - Pain medication may not eliminate/relieve pain – follow up with Dr. or registered staff

Challenges with Pain

- Pain can be difficult to assess and treat for several reasons:
 - Older people may not report pain because they don't want to be a burden; increased stoicism or they may have sensory, cognitive or communicative impairments that make it more difficult to indicate the sensations they are feeling
 - Sometimes staff may not inquire about pain – recall that up **to 70%** of LTC residents have untreated pain
 - Pain is a real experience for 7 out of 10 residents you work with and something can be done to reduce this
 - Ageist attitude regarding pain - an expected consequence of the ageing process
 - Cognitive impairment challenges assessment – some pain scales are too difficult to use

Consequences of Pain

- Untreated or under treated pain can result in other problems for residents including:
 - decreased enjoyment if recreational activities/hobbies
 - decreased mobility, impaired posture and balance - increased fall risk
 - decreased socialization
 - anxiety
 - depression
 - sleep disturbances
 - decreased appetite and weight loss
 - decreased memory
 - bowel and bladder function changes
 - decreased adl participation
 - increased irritability
 - resistance to care

Best Practice

- Nurses in all practice settings should assess clients for pain using a validated tool, such as the Numeric Rating Scale or the Verbal Analogue Scale

Heart and Stroke Foundation of Ontario and Registered Nurses' Association of Ontario (2005).

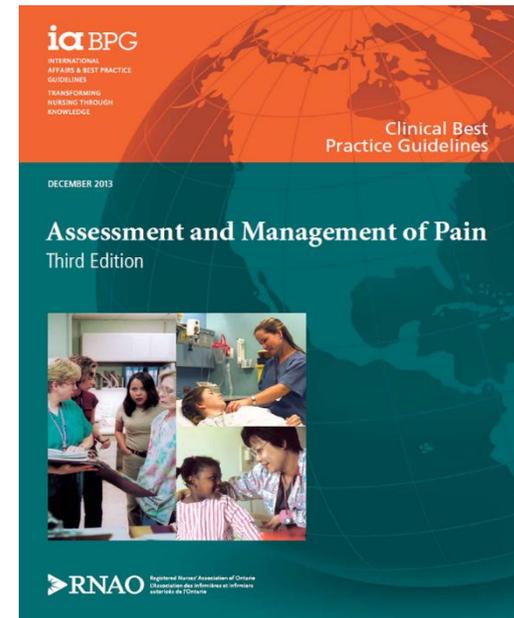
Stroke Assessment Across the Continuum of Care. Toronto: Heart and Stroke Foundation of Ontario and Registered Nurses' Association of Ontario, 39.

- A Pain Rating Scale can be helpful to ask the resident -
 - how their pain feels at its worst
 - how the pain feels most of the time
 - how the pain feels at its least
 - how the pain changes with treatment

Best Practice

Nurses have an important role in screening for pain. Randomized control trials report screening is essential for effective pain management. Although other health care professionals are involved in the assessment and management of a resident's pain, nurses have the most contact and positions them uniquely to screen and move forward with a comprehensive assessment of the residents pain experience and participate in a collaborative and comprehensive pain management care plan.

RNAO Clinical Best Practice Guideline
Assessment and Management of Pain
Third Edition, December 2013



Pain Strategies/Interventions

- Do not pull on the affected arm - care must be taken to protect the arm from stretch injury and yet maintain normal ROM
- Do not let the arm dangle – positioning is critical - use of resting hand splints and wheelchair arm support is important to properly support the arm and shoulder
- Do not raise the arm above the shoulder – care providers need to carefully monitor upper limb positioning in stroke residents who are unaware/neglecting their affected side and do not notice if their arm/shoulder is poorly positioned be aware that **persistent pain makes it difficult for residents to participate in their own care. Check to ensure that the resident has had their pain medication before starting their care**

ADL Strategies

Bathing

- When bathing a stroke resident who may be in pain:
 - always keep the affected arm supported while washing
 - do not let the affected arm dangle at the side of the body
 - always support the person's entire arm at the wrist and elbow while moving during any activity

Dressing

- Dress the weaker arm first
- Choose easy fitting clothing

ADL Strategies continued

Eating

- When feeding stroke residents who are in pain:
 - Ensure the resident is positioned for safety with eating and comfort eg. Upright in midline position with arm supported
 - Consider adaptive utensils to assist with gripping when hands are painful

Walking/Transferring

- When transferring or walking with stroke resident who may be in pain:
 - ensure the resident is wearing proper footwear
 - ensure they are set up properly for transfer
 - request an OT/PT assessment for transfer and walking strategies

The Interprofessional Team

RNAO Recommendation:

- Initiate and maintain collaborative processes within the team, especially in situations of increasing resident complexity, to improve resident outcomes
- Interdisciplinary collaboration is critical to the best possible outcomes for the stroke resident

Why?

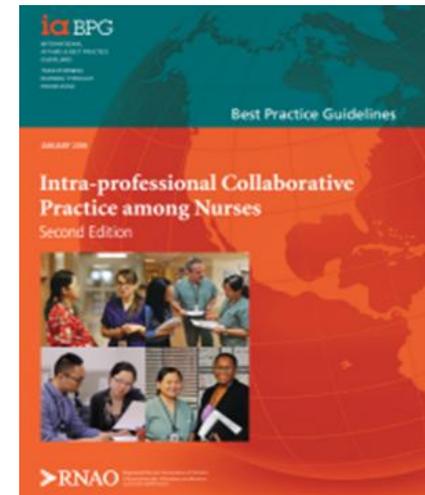
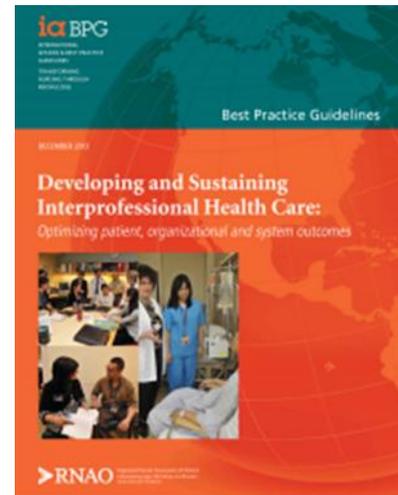
- Communication
- Treatment specificity and specialization
- Scope of Practice
- Resident complexity
- Best evidenced-practice
- Shared decision making
- Quality of Work Environment
- Safety

RNAO Best Practice Guidelines

Intra-professional Collaborative Practice among Nurses 2nd ed., 2016

Developing and Sustaining Interprofessional Health Care:

Optimizing patient, organizational and system outcomes 2013



Best Practice

RNAO Recommendation 2.2

- Establish a comprehensive plan of care that incorporates the goals of the person and the interprofessional team and addresses:
 - Assessment findings
 - The person's beliefs and knowledge and level of understanding : and
 - the person's attributes and pain characteristics

RNAO Recommendation 3.3

- Teach the person, their family and caregivers about the pain management strategies in their plan of care and address known concerns and misbeliefs.

Best Practice continued

RNAO Recommendation 4.1

Assess the person's response to the pain management interventions consistently using the same re-evaluation tool. The frequency of reassessments will be determined by:

- presence of pain
- pain intensity
- stability of the person's medical condition
- type of pain
- practice setting

RNAO Recommendation 4.2

Communicate and document the person's responses to the pain management plan

**Pain is inevitable.
Suffering is optional.**

- M. Kathleen Casey

Stroke Care Plans

The 12 Stroke Specific Care Plans :

- 1.) ADL Care Plans – Final - June 2016
- 2.) Behavior Change - Final – June 2016
- 3.) Bowel Bladder Continence Final – June 2016
- 4.) Cognition Care Plans – Final – June 2016
- 5.) Communication – Final – June 2016
- 6.) Depression – Final - June 2016
- 7.) Leisure – Final – June 2016
- 8.) Mobility Positioning Transfers – Final –June 2016
- 9.) Nutrition Hydration Swallowing – Final- June 2016
- 10.) Pain – Final – June 2016**
- 11.) Perception – Final – June 2016
- 12.)Skin Care – Final –June 2016

Stroke Care Plans for Long-Term Care. Clinical Tools and Resources for Implementation: Community Re-engagement. CorHealth Ontario. Retrieved from

<https://www.corhealthontario.ca/resources-for-healthcare-planners-&-providers/stroke-general/qbp/clinical-tools-&-resources/community-reengagement>

Stroke Resources

- Ontario Stroke Network: www.ontariostrokenetwork.ca
- Canadian Stroke Best Practice Guidelines: www.strokebestpractices.ca
- RNAO Best Practice Guidelines: <https://rnao.ca/bpg>
- Long Term Care Best Practices Toolkit, 2nd edition: <http://ltctoolkit.rnao.ca>
- Stroke Care Plans: www.swostroke.ca
- Taking Action for Optimal Community and Long Term Care (TACLS) : www.strokebestpractices.ca

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 - *Central East Behavioural Supports Ontario Toolkit*. <http://centraleast.behavioursupportsontario.ca>
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Questions ?



Thank you !