

Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

Volume 2, Issue 1

January 2007

# BP Blogger

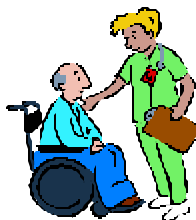
## Myth Busting: The Pain Issue

### Inside this issue:

<b>Myth 1:</b>	1
Pain is normal with aging, feel less pain	
<b>Myth 2:</b>	1
It's for attention, put up with it, stop whining	
<b>Myth 3:</b>	2
Residents get addicted to pain drugs	
<b>Myth 4:</b>	2
Can't assess pain in residents with cognitive impairments / dementias	
<b>BPGs and Resources</b>	2
<b>Contacts for Information</b>	1 & 2

### Myth 1: Pain is normal with aging, feel less pain

Contrary to popular belief, there is no conclusive evidence that aging is associated with increased tolerance to pain. In fact, **43% to as high as 84% percent of residents experience pain.** And for those with pain, **anywhere from 24% to 51% experience pain daily.** Pain is common in the LTC setting and there are times when **pain is under-recognized** which may result in inadequate treatment. Almost all LTC residents have conditions often associated with pain such as low back disorders, osteoporosis, neuropathies, headaches, fibromyalgia, renal and



gastro-intestinal disorders, oral problems, peripheral vascular disease, post-stroke syndrome, pressure ulcers, previous fractures, arthritis, immobility, contractures and/or amputation. Residents may have injuries or daily care needs that require invasive treatment procedures such as nasogastric tubes, central lines, indwelling catheters, wound dressings, and personal care (e.g. bathing, positioning) or are in the last days of their life. Pain should not be under-estimated and staff should be highly suspicious that it may be pain that the resident is experiencing.

### Myth 2: Its for attention, put up with it, stop whining

**Pain** not only **lowers** the resident's **quality of life** but also predisposes them to potentially harmful consequences such as poorer sleep and nutrition, depression, anxiety, agitation, less activity, gait problems, falls, slower rehabilitation, delayed healing, multiple medication use, cognitive impairment, confusion and less socialization. Sadly, the **older person tends to under-report pain**, especially for those residents who are cognitively impaired, may have communication difficulties or strong beliefs



about pain, it may lead to inadequate treatment. Residents express pain as a significant problem for which they perceive there is little that can be done. They are reluctant to talk about their pain and believe that they have to "put up and live" with the pain, and they don't want to bother staff. When they do discuss their pain with staff and ask for relief, they feel that they are whining.

### More information on This and Other Best Practices

- **Contact** your **Regional LTC Best Practices Coordinator**. They can help you with Best Practices Info for LTC. **Find them at:** [www.shrtn.on.ca](http://www.shrtn.on.ca) click on these links "Tools and Resources" → "Current Research BP Practice Initiatives" → "LTC Regional BP Coordinators"
- **Check out** the **Hamilton Long Term Care Resource Centre** [www.rgpc.ca](http://www.rgpc.ca)
- **Surf the Web** for BPGs. Some sites and resources are listed on pg 2.



Best Practice in LTC Initiative Central South and  
The Long Term Care Resource Centre Hamilton

Hamilton LTC  
Resource Centre

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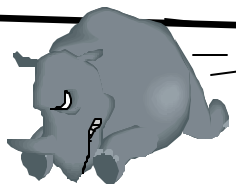
Find it on the Web at  
[www.rgpc.ca](http://www.rgpc.ca) or [www.shrtn.on.ca](http://www.shrtn.on.ca)

## Myth 3: Residents get addicted to pain drugs



**Pain should always be addressed even if the cause is unknown, never ignore pain.** Less than 1% of people have become addicted to opioids (e.g. morphine) given for pain relief. In the LTC setting, the **comfort and well-being** of the resident must be paramount and serve as the foundation for effective management of pain. Adequate pain management should be sought for each resident who is experiencing pain. When medication is needed, the goal should be to **improve** function and balance the benefits of medication (pain control) against the risks (side effects). Negotiate the goals for pain management and set targets for satisfactory pain relief with the resident and family. Opioid analgesics are appropriate for moderate to severe pain especially when the pain is unresponsive to other medications and normally should never be used as the first line treatment. Although concerns about drug abuse may influence medication choices, they do not justify failure to treat severe pain. Administering opioids to residents may be associated with increased risk of symptoms such as anorexia, falling and altered mental state, but it does not cause loss of control or addictive behaviour. Opioids can be safely administered to residents with careful titration and monitoring. As a general rule, it's good to "start low" and "go slow" until the target for pain relief is reached.

## Myth 4: Can't assess pain in residents with cognitive impairments / dementias



Pain in the older persons with cognitive impairment/dementia often can be reliably detected and effectively treated despite their difficulties to or inability to communicate their pain. These residents may not show the typical signs and symptoms to the same degree as others making pain response different. In fact, those cognitively impaired are often **able to report feeling pain** and are even able to use pain scales adapted for their needs such as numerical or categorical scales. They often are confused by the faces on scales. It is important to understand that they maybe **expressing their pain through their behaviours**. Always

consider that their behaviours maybe a result of the pain they are having, and review their medical conditions, treatments and activities that maybe aggravating their pain. **Residents with dementia may express their pain by:**

- Frowning, grimacing, fearful facial expressions, grinding teeth
- Making strange noises, screaming, cursing
- Bracing, guarding, rubbing
- Fidgeting, increasing/recurring, restlessness, spacing, wandering, exit-seeking
- Striking out, physical and/or verbal agitation
- Eating or sleeping poorly
- Sighing, groaning, crying, breathing heavily
- Changing activity levels, grabbing
- Resisting certain movements during care
- Change in gait or behaviour
- Loss of function
- Requests for attention or help, complaining or whining, repetitive sentences or questions

**Check out these Best Practices & Guidelines. Answers to the Myths came from them. Find out more!**

### Canadian:

Registered Nurses Association of Ontario. (2002). Assessment and management of pain. Toronto, ON: Author. [www.rnao.org](http://www.rnao.org)

MAREP & Alzheimer Society of Hamilton & Halton, Brant, Haldimand-Norfolk & Niagara Region. (2006). Managing and accommodating responsive behaviours in dementia care. A resource guide for long term care. Waterloo, ON: University of Waterloo. [www.marep.uwaterloo.ca](http://www.marep.uwaterloo.ca)

Alzheimer's Society of Hamilton and Halton (2006). Pain management. Providing care for persons with dementia at the end-of-life. Hamilton, ON: Author. [www.alzheimer.interlynx.net](http://www.alzheimer.interlynx.net)

### Others:

American Medical Directors Association. (2003). Pain management in the long-term care setting. Clinical practice. Columbia, MD: Author. [www.amda.com](http://www.amda.com)

University of Iowa Gerontological Nursing Interventions Research Center (2005). Evidence-based practice guideline. Persistent pain management. Iowa City, Iowa: Author [www.nursing.uiowa.edu](http://www.nursing.uiowa.edu)

American Geriatrics Society (2002). The management of persistent pain in older persons. New York, NY: Autho. [www.americangeriatrics.org](http://www.americangeriatrics.org)

**Special thanks in Central Ontario** to the Brant LTC Best Practices Workgroup, Alzheimer's Society PRCs of Central Ontario, Palliative Pain and Symptom Management Consultant-PPSM Program Brant, Haldimand and Norfolk Counties, S.Kaasalainen-McMaster University School of Nursing, Regional Geriatric Program Central, Seniors Health Research Transfer Network