



# POLICY AND PROCEDURE

# PAIN ASSESSMENT AND MANAGEMENT



**Developed by:**  
**Toronto and Central East**  
**Best Practice in LTC Initiative**  
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Disclaimer: This policy and procedure has been developed collaboratively by a group of LTC Homes in Toronto and Central East along with the Regional Best Practice Coordinators from those regions. It is based on the RNAO Best Practice Guidelines on Assessment and Management of Pain and other best practice sources on the same topic. It has been reviewed by stakeholders from various LTC Homes and representatives of the Toronto Best Practice Implementation Steering Committee.

This policy and procedure is to be used as a guideline at the discretion of the LTC Homes.

**POLICY AND PROCEDURE  
PAIN ASSESSMENT AND MANAGEMENT**

**POLICY:**

Each resident must have a formal pain assessment on admission and be always re-assessed on re-admission, quarterly, and at least every shift. Residents experiencing pain must be treated immediately using non-pharmacological and pharmacological methods to maximize function and promote quality of life. Consent to treatment must always be obtained from the resident and/or Substitute Decision Maker (SDM)

**PURPOSE:**

The purpose of pain management is to:

1. Address resident's individual needs with respect to acute and chronic pain.
2. Initiate appropriate strategies and interventions.
3. Provide learning opportunities for staff, residents, families and SDMs.
4. Monitor and evaluate resident outcome.

**PREAMBLE:**

The interdisciplinary team plays a significant role in pain management, promotes open communication and monitors the outcome of the program.

| Team Members                  | Roles and Responsibilities   |
|-------------------------------|--|
| Director of Care or Designate | <ul style="list-style-type: none"> <li>• Facilitates the implementation of pain management procedures for each individual resident.</li> <li>• Collects data, analyzes statistics, identifies trends, evaluates outcomes and presents quarterly statistics to an interdisciplinary committee.</li> <li>• Seeks advice from experts to support team decisions.</li> <li>• Coordinates education processes relating to pain management.</li> </ul>                                     |
| Nursing (RN and RPN)          | <ul style="list-style-type: none"> <li>• Conducts and documents a pain assessment,               <ul style="list-style-type: none"> <li>○ On admission</li> <li>○ Re-admission</li> <li>○ Quarterly</li> <li>○ Initiation of a pain medication or prn analgesic</li> <li>○ Behaviours exhibited by resident that may herald the onset of pain</li> <li>○ Change in condition with onset of pain</li> <li>○ Resident states pain severity is a 4/10 or greater</li> </ul> </li> </ul> |

| Team Members   | Roles and Responsibilities  |
|--|---|
| Nursing (RN and RPN)                                 | <ul style="list-style-type: none"> <li>○ Diagnosis of painful disease</li> <li>○ History of unexpressed pain</li> <li>○ Receiving pain related medication for greater than 72 hours</li> <li>○ Distress related behaviours or facial grimace</li> <li>○ Resident/family/staff/volunteers indicate pain is present</li> <li>● Initiates a pain management flow record when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions.</li> <li>● Initiates, communicates, and reviews the plan of care with the interdisciplinary team to address each individual resident's pain.</li> <li>● Makes referral to interdisciplinary team members.</li> <li>● Provides education to family/resident about pain management.</li> <li>● Evaluates the plan of care and update as necessary.</li> </ul> |
| Health Care Aide/Personal Support Worker             | <ul style="list-style-type: none"> <li>● Recognizes and reports resident verbalizations and behaviours indicative of discomfort.</li> <li>● Reports decrease in any of the following: physical and social activity, energy, appetite, continence pattern, and hours of sleep.</li> <li>● Notifies RN/RPN 1 hour before bathing, dressing, activities, and turning if these activities regularly cause the resident to experience pain.</li> <li>● Monitors residents.</li> </ul>  |
| Occupational Therapist (OT)/<br>Physiotherapist (PT) | <ul style="list-style-type: none"> <li>● Carries out system assessments as appropriate for musculoskeletal &amp; neurological conditions and contributing pain factors</li> <li>● Develops, implements and carries out therapeutic interventions for the assessed conditions including adjunct non-pharmacological pain interventions, therapeutic modalities and/or joint supports such as splints, braces and other positioning aids.</li> <li>● Evaluates and advises the interdisciplinary team of the impact of pain on mobility and ADL status and recommends assistive mobility equipment and adaptive aids.</li> <li>● Educates residents, family and staff on use of equipment/devices/aids.</li> <li>● Evaluates and reassesses resident status</li> </ul>  |
| OT Assistant/PT Assistant/Rehabilitation Assistant   | <ul style="list-style-type: none"> <li>● Carries out assigned treatments relating to adjunct pain relieving modalities, mobility and ADL status.</li> <li>● Monitors resident responses and reports responses to OT/PT &amp; interdisciplinary team.</li> <li>● Monitors/inspects assistive mobility equipment, adaptive aids and joint support/positioning devices on a regular basis.</li> </ul>  |
| Registered Dietitian                                 | <ul style="list-style-type: none"> <li>● Completes nutritional risk assessment within 7 days.</li> <li>● Orders appropriate diet and supplements as described by the LTC Homes policy. A Physician co-signature is required.</li> <li>● Makes recommendations to Physicians.</li> <li>● Suggests fluid and nutritional intake to reduce possibility of constipation.</li> </ul>   |
| Recreation Therapist/Restorative                     | <ul style="list-style-type: none"> <li>● Involves the resident in group or one to one exercise, range of motion, activity, complementary therapies or social programs as appropriate to the resident's assessed level/type of pain and contributing conditions.</li> <li>● Recognizes and reports resident verbalizations and behaviours indicative of discomfort.</li> <li>● Reports resident changes to RN.</li> </ul>  |
| Physician  | <ul style="list-style-type: none"> <li>● Identifies, implements and monitors medical interventions to address pain.</li> </ul>  |
| Social Work  | <ul style="list-style-type: none"> <li>● Provides support to resident's psychosocial needs.</li> <li>● Counsels and supports families as needed.</li> </ul>   |

| <b>Team Members</b>     | <b>Roles and Responsibilities</b>  |
|-------------------------|--|
| Pharmacist              | <ul style="list-style-type: none"> <li>• Reviews medications and supplements.</li> <li>• Provides consultation services.</li> <li>• Provides education.</li> </ul>       |
| Podiatrist/Chiropracist | <ul style="list-style-type: none"> <li>• Assesses for nail care and advises for the prescription of appropriate footwear for the resident's individual needs.</li> </ul> |
| Chaplain                | <ul style="list-style-type: none"> <li>• Provides support to resident's spiritual/cultural needs.</li> <li>• Counsels and supports families.</li> </ul>                  |
| Family                  | <ul style="list-style-type: none"> <li>• Attends the multidisciplinary conference.</li> <li>• Works with staff and resident to support plan of care.</li> </ul>          |

## **PROCEDURE:**

### **A. Pain Assessment**

The interdisciplinary team will:

1. Conduct and document a pain assessment,
  - On admission
  - Re-admission
  - Quarterly
  - Initiation of a pain medication or prn analgesic
  - Behaviours exhibited by resident that may herald the onset of pain
  - Change in condition with onset of pain
  - Resident states pain severity is a 4/10 or greater
  - Diagnosis of painful disease
  - History of unexpressed pain
  - Receiving pain related medication for greater than 72 hours
  - Distress related behaviours or facial grimace
  - Resident/family/staff/volunteers indicate pain is present
2. Initiate a pain management flow record when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions. This initiation is based upon evidence gathered using the Pain Assessment Tool to ensure that those with identified pain are monitored and that pain is brought under control.
3. Develop interventions both non-pharmacologically and pharmacologically to address resident's pain.
4. Initiate a written plan of care within 24 hours of admission and update as necessary.
5. Complete interdisciplinary team assessments.
6. Evaluate and document resident outcome.

### **B. Care Planning**

The interdisciplinary team will:

1. Adhere to the following guiding principles of pain assessment and management:
  - a) Residents have the right to the best pain relief possible.
  - b) Unrelieved acute pain should be prevented where possible.
  - c) Unrelieved pain requires a critical analysis of pain-related factors and interventions.
  - d) Pain is subjective, multidimensional and highly variable experience for everyone regardless of age or special needs.

- e) Interdisciplinary team is legally and ethically obligated to advocate for change in the treatment plan where pain is inadequate.
  - f) Collaboration with residents and families is required in making pain management decisions.
  - g) Effective pain assessment and management is multidimensional in scope and requires coordinated interdisciplinary intervention.
  - h) Clinical competency in pain assessment and management demands ongoing education.
  - i) Effective use of opioid analgesics should facilitate routine activities such as ambulation, physical therapy, and activities of daily living.
2. Anticipate pain that may occur during procedures such as dressing changes, and combine pharmacologic and non-pharmacologic options for prevention.
3. Follow the procedures below when initiating the **Pain Assessment Tool** (Appendix A):
- a) **For new pain or intermittent pain:**
    - Discuss and develop a plan of care with resident/family/substitute decision maker.
    - Consider non-pharmacological and pharmacological interventions.
    - Check resident's chart for a PRN analgesic order and administer PRN medication.
    - Initiate **Pain Management Flow Record**.
  - b) **For pain that is not managed**
    - Repeat the PRN as necessary if pain is less than 4/10 and the resident is not in distress.
    - Consider around the clock dosing of current PRN medication if pain is less than 4/10 and is deemed to be chronic in nature.
    - Communicate with physician and get the medication ordered on a regular basis if dosing is effective.
    - Communicate with the team and the physician if pain is less than 4/10 after 24 hours of monitoring.
    - Initiate **Pain Management Flow Record** if the pain is greater than 4/10.
  - c) **Key for Pain Assessment Tool**
    - Location of pain:**
      - Indicate on the part of the body where the resident reports feeling pain.
      - If pain starts at a certain point then travels, indicate the direction and extent of the travel with an arrow.
      - Use numbers to distinguish the different pain locations if the resident indicates more than one type or location of pain.
    - Severity**
      - Ask the resident to answer the questions in the table as they relate to each identified pain including rating the severity of his/her pain using the numerical 0-10 rating scale.
      - Use the facial grimace scale as an objective measure if the resident is unable to rate the severity of his/her pain using the numerical rating scale.
    - Quality**
      - Go over each pain location to identify the appropriate descriptors from the list.
      - Record the descriptive word used by resident beside "other" if the word to describe pain differs from the list.
      - Prompt the resident with the word list provided if he/she has difficulty using word descriptors.
    - Effects of Pain on Activities of Daily Living (ADLs)**
      - If any of the pains identified are affecting any of the listed ADLs, tick "yes" or "no" and comment in what way.
      - Ask if the resident feels that help is needed with any of the activities identified as a problem or if they are content to live with it. Refer to the appropriate interdisciplinary

team member and address in the plan of care if it has been identified that the resident requires assistance.

#### **Effects of Pain on Quality of Life**

- Ask resident what he/she likes to do that he/she can't because of the pain.
- Have the resident indicate which activity can no longer be done that is important to him/her.
- Inquire from the resident how the interdisciplinary team members can help.

#### **Symptoms**

Have the resident identify from the listed symptoms which ones are affecting his/her quality of life.

#### **Behaviours**

- Have the resident identify disturbing behaviours if possible and/or the assessor will identify and check exhibited behaviours.

#### **Past Pain Management**

- Have the resident describe the pain incident and his/her coping methods.

#### **Support Systems**

- Ask the resident to identify who is available for support in the event of pain or symptom crisis.

#### **Other Concerns Related to Pain**

- Discuss any concerns that the resident/family/substitute decision maker has about pain management.

#### **Nursing Pain Diagnosis**

- Tick off the appropriate nursing pain diagnosis(es) and list them on the care plan
- Document as per policy.
- Discuss with resident the problems identified and treatment options for better pain management.

4. Follow the procedures below when initiating the pain management flow record (Appendix B):
  - a) Keep the current "pain management flow record" in the medication administration record (MAR).
  - b) File the completed pages with the medication administration records in the resident's chart.
  - c) Under "Regular Pain Medication" include any medication which would have an effect on the resident's pain and indicate the date the order was received.
  - d) Under "Breakthrough Pain Medication" include any medication which would have an effect on the resident's pain and note the date the order was received.
  - e) Under non-pharmacological treatments include any treatments, e.g., ice packs, massage, etc. which would have an effect on the resident's pain.
  - f) Indicate the date and time of assessment.
  - g) Indicate the severity of the pain pre-treatment by showing the resident a pain-rating tool with a 0-10 scale; ask "What number would you give your pain right now?" Residents who cannot relate to numbers may use the descriptive words on the tool.
  - h) Indicate the location of pain at the time of giving the pain medication.
  - i) Indicate the quality of pain per the key terms at the bottom of the flow record.
  - j) Indicate the time of administration of the regular medication and/or breakthrough medication.
  - k) Indicate type of non-pharmacological treatment administered.
  - l) Reassess the severity of the pain using a scale within one hour after administration of pain medication to monitor the effectiveness of the medication.

- m) Ask the resident, "Is relief acceptable to resident?" indicate a "yes" or "no". If answer is "no" re-evaluate plan of care. If resident is unable to answer the question, assess if there is a decrease in behavioural discomfort.
- n) Indicate an asterisk \* in any of the columns to refer to the nursing notes for further documentation
- o) Discontinue use of this form on a regular basis when pain is stable using the **Principle of "3s"**, that's for 3 consecutive days of pain rated at 3 or less and using 3 or less "Breakthrough Pain" doses/24hours.
- p)

**Notify the Physician** when:

- More than 4 "Breakthrough Pain" doses are needed in a 24 hours period depending on the individual circumstances.
- The resident consistently reports pain of greater than 4/10 for 24 to 48 hours depending on individual circumstances.
- The resident reports sudden onset of new pain.

5. Provide the resident and their family with information about pain and the measures used to treat it, with particular attention focused on correction of myths and strategies for the prevention and treatment of side effects (e.g., administration of antiemetic for presence of nausea and vomiting, bowel program to prevent constipation, and monitoring for drowsiness/sedation and ensuring that the physician is notified if confusion or hallucinations accompany drowsiness).

### **C. Non-pharmacological Interventions**

The interdisciplinary team will:

1. Institute strategies for specific types of pain such as superficial heat and cold, massage, relaxation, imagery and pressure or vibration, unless contraindicated.
2. Implement psychosocial interventions that facilitate coping of the individual early in the course of treatment.
3. Institute psycho-educational interventions as part of the overall plan of treatment for pain management.
4. Implement cognitive-behavioural strategies combined with multidisciplinary rehabilitative approach for treatment of chronic non-malignant pain.

Note: See Appendix C for description of some of the non-pharmacological methods of pain control.

### **D. Pharmacological Interventions**

The interdisciplinary team will:

1. Ensure that the selection of analgesics is individualized to the resident, taking into account:
  - the type of pain (acute or chronic, nociceptive and/or neuropathic);
  - intensity of pain; potential for analgesic toxicity (age, renal impairment, peptic ulcer disease, thrombocytopenia);
  - general condition of the resident;
  - concurrent medical conditions; and
  - response to prior or present medications.
2. Advocate for the least invasive route such as oral route for pain medication administration.

3. Advocate for acetaminophen as the drug of choice for relieving mild to moderate musculoskeletal pain. The maximum dosage of acetaminophen should not exceed 4000 mg per day.

Note: See Appendix D for the Analgesic Ladder.

4. Use non-steroidal, anti-inflammatory drugs (NSAIDs) with caution.
  - High-dose, long-term NSAID use should be avoided.
  - When used chronically, NSAIDs should be used as needed, rather than daily or around the clock.
  - Consider short-acting NSAIDs to avoid dose accumulation.
  - Avoid NSAIDs in residents with abnormal renal function, history of peptic ulcer disease, bleeding diathesis.
5. Consider opioid analgesics for relieving moderate to severe pain, especially nociceptive pain.
  - Opioids for episodic (e.g., chronic recurrent or non-continuous) pain should be prescribed as needed, rather than around the clock.
  - Long-acting or sustained-release analgesic preparations should be used only for continuous pain.
  - Breakthrough pain should be identified and treated by the use of fast-onset, short acting preparations.
6. Assess and prevent common side effects of opioids.
7. Recognize and treat all potential causes of side effects taking into consideration medications that potentiate opiate side effects:
  - Sedation – sedatives, tranquilizers, antiemetics;
  - Postural hypotension – antihypertensives, tricyclics;
  - Confusion – phenothiazines, tricyclics, antihistamines and other anticholinergics.
8. Assess residents taking opioids for the presence of nausea and/or vomiting, paying particular attention to the relationship of the symptom to the timing of analgesic administration.
9. Ensure that residents taking opioid analgesics are prescribed an antiemetic for use on an “as needed” basis with routine administration if nausea/vomiting persist.
10. Assess the resident for a bowel program to prevent constipation.
11. Consider non-opioid analgesic medications for residents with neuropathic pain and some other chronic pain syndromes.
  - Agents with the lowest side-effect profiles should be chosen preferentially.
  - Therapy should begin with the lowest possible doses and increased slowly because of the potential for toxicity of many agents.
12. Monitor residents taking analgesic medications.
13. Consider alternative therapy such as botox injection to reduce contraction.

#### **References:**

AGS Panel on Chronic Pain in Older Persons. (1998). The Management of Chronic Pain in Older Persons. *Journal of the American Geriatrics Society*, 46, 635-651.

Registered Nurses' Association of Ontario. (2002). *Assessment and Management of Pain*. Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: [www.rnao.org/bestpractices](http://www.rnao.org/bestpractices)

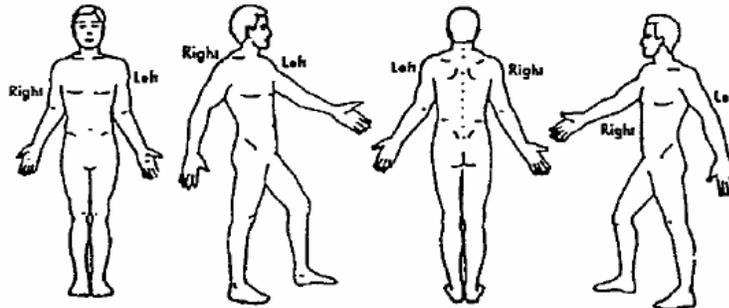
## APPENDIX A: Pain Assessment Tool

Addressograph

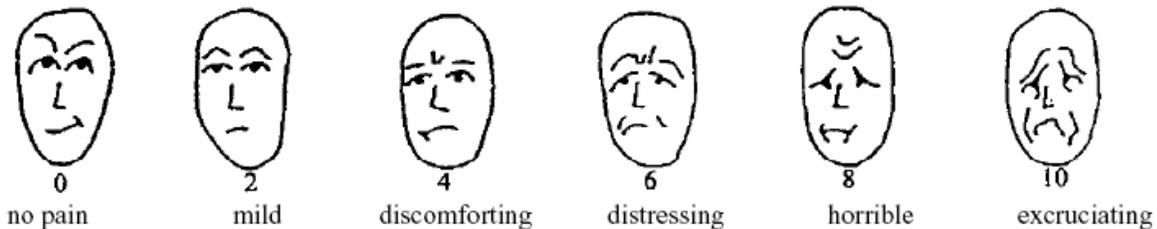
**Reason for assessment:**

- New admission     Readmission     Further Assessment  
 Change in condition     Quarterly

**1. Location of pain:**



**2. Severity of Pain:**



| QUESTIONS  | COMMENTS |
|--|----------|
| What is the present level of pain?<br><b>(if no pain is present complete sections 6 and 7)</b> |          |
| What is the rate when the pain is at its least?  |          |
| What makes the pain better?  |          |
| What is the rate when the pain is at its worst?  |          |
| What makes the pain worse?   |          |
| Is the pain continuous or intermittent?  |          |
| When did the pain start?   |          |
| What do you think is the cause of this pain?   |          |
| What level of pain are you satisfied with?<br>(if 0 is unattainable)                           |          |

**3. Quality: Indicate the words that describe the pain**

|                                  |                                    |   |                                     |                                      |                                     |
|----------------------------------|------------------------------------|---|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> aching  | <input type="checkbox"/> throbbing | <input type="checkbox"/> shooting       | <input type="checkbox"/> stabbing   | <input type="checkbox"/> gnawing     | <input type="checkbox"/> sharp      |
| <input type="checkbox"/> burning | <input type="checkbox"/> tender    | <input type="checkbox"/> exhausting     | <input type="checkbox"/> tiring     | <input type="checkbox"/> penetrating | <input type="checkbox"/> numb       |
| <input type="checkbox"/> nagging | <input type="checkbox"/> hammering | <input type="checkbox"/> pins & needles | <input type="checkbox"/> unbearable | <input type="checkbox"/> tingling    | <input type="checkbox"/> stretching |
| <input type="checkbox"/> pulling | other:                             |   |                                     |                                      |                                     |

**4. Effects of pain on activities of daily living**

| Activities of daily living     | Yes | No | Comments |
|--------------------------------|-----|----|----------|
| sleep and rest                 |     |    |          |
| social activities              |     |    |          |
| appetite                       |     |    |          |
| physical activity and mobility |     |    |          |
| emotions                       |     |    |          |
| sexuality/intimacy             |     |    |          |

**5. Effects of pain on quality of life**

What would you like to do now that you can't do because of the pain or What activity would improve your quality of life?

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**6. Symptoms:** What other symptoms are being experienced?

|                                       |                                   |  |                                  |                                   |                                     |                                 |
|---------------------------------------|-----------------------------------|--|----------------------------------|-----------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> constipation | <input type="checkbox"/> nausea   | <input type="checkbox"/> vomiting        | <input type="checkbox"/> fatigue | <input type="checkbox"/> insomnia | <input type="checkbox"/> depression | <input type="checkbox"/> drowsy |
| <input type="checkbox"/> sore mouth   | <input type="checkbox"/> weakness | <input type="checkbox"/> short of breath | other:                           |                                   |                                     |                                 |

**7. Behaviours:** What behaviours are present that may be a result of pain or treatment?

|  |  |   |                                     |   |
|--|--|---|-------------------------------------|---|
| <input type="checkbox"/> calling out           | <input type="checkbox"/> restlessness            | <input type="checkbox"/> disorientation   | <input type="checkbox"/> not eating | <input type="checkbox"/> pacing           |
| <input type="checkbox"/> not sleeping          | <input type="checkbox"/> withdrawn               | <input type="checkbox"/> groaning/moaning | <input type="checkbox"/> rocking    | <input type="checkbox"/> new immobility   |
| <input type="checkbox"/> tense                 | <input type="checkbox"/> distressed              | <input type="checkbox"/> distracted       | <input type="checkbox"/> crying     | <input type="checkbox"/> inexpressive     |
| <input type="checkbox"/> fists clenched        | <input type="checkbox"/> striking out            | <input type="checkbox"/> knees pulled up  | <input type="checkbox"/> frowning   | <input type="checkbox"/> facial grimacing |
| <input type="checkbox"/> resistant to movement | <input type="checkbox"/> pulling or pushing away | <input type="checkbox"/> sad              | <input type="checkbox"/> frighten   | other                                     |

**8. Past pain management**

Has a significant degree of pain been experienced in the past? How was that managed?

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Past use of pharmacological and non-pharmacological pain management?

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**9. Support system:** \_\_\_\_\_

**10. Other concerns related to pain** \_\_\_\_\_

**11. Nursing pain diagnosis:**

|                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> visceral     | <input type="checkbox"/> somatic (muscle or bone) | <input type="checkbox"/> raised intracranial pressure |
| <input type="checkbox"/> naturopathic | <input type="checkbox"/> mixed                    | <input type="checkbox"/> unknown                      |

**Date Care Plan updated:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Assessment Date:** \_\_\_\_\_

Adapted from Registered Nurses' Association of Ontario. (2002). *Assessment and Management of Pain*. Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: [www.rnao.org/bestpractices](http://www.rnao.org/bestpractices)

## APPENDIX B: Pain Management Flow Record

Regular Pain Medication: \_\_\_\_\_  
Date Order Received: \_\_\_\_\_

Breakthrough Pain Medication: \_\_\_\_\_  
Date Order Received: \_\_\_\_\_

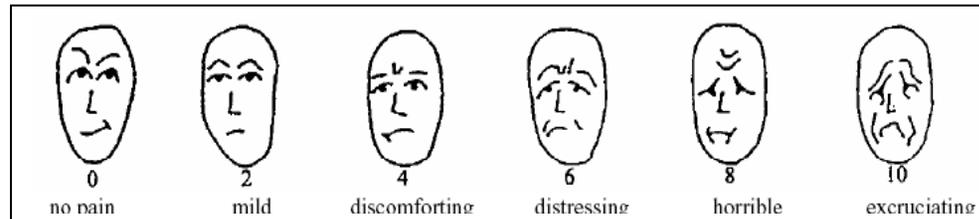
Non-Pharmacological treatments: \_\_\_\_\_

Addressograph

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| Date  |  |  |  |  |  |  |  |
| Time of assessment  |  |  |  |  |  |  |  |
| Severity of pain pre-treatment  |  |  |  |  |  |  |  |
| Location of pain  |  |  |  |  |  |  |  |
| Quality of pain   |  |  |  |  |  |  |  |
| Regular pain medication time  |  |  |  |  |  |  |  |
| Breakthrough pain medication time   |  |  |  |  |  |  |  |
| Non-pharmacological treatment: type   |  |  |  |  |  |  |  |
| Signature and designation pre-treatment   |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |
| Time of post assessment   |  |  |  |  |  |  |  |
| Severity of pain post treatment   |  |  |  |  |  |  |  |
| Is relief acceptable to resident?<br>If answers is <b>no</b> , has plan of care been updated? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Signature and designation post-treatment  |  |  |  |  |  |  |  |

Indicate an asterisk \* to refer in the nursing notes for further documentation.

**Severity of pain:**



**Quality of pain:**

|                |              |               |                   |            |
|----------------|--------------|---------------|-------------------|------------|
| a) aching      | b) throbbing | c) shooting   | d) stabbing       | e) gnawing |
| f) sharp       | g) burning   | h) tender     | i) exhausting     | j) tiring  |
| k) penetrating | l) numb      | m) nagging    | n) hammering      | o) pulling |
| p) unbearable  | q) tingling  | r) stretching | s) pins & needles |            |
| t) other:      |              |               |                   |            |

Adapted from Registered Nurses' Association of Ontario. (2002). *Assessment and Management of Pain*. Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: [www.nao.org/bestpractices](http://www.nao.org/bestpractices)

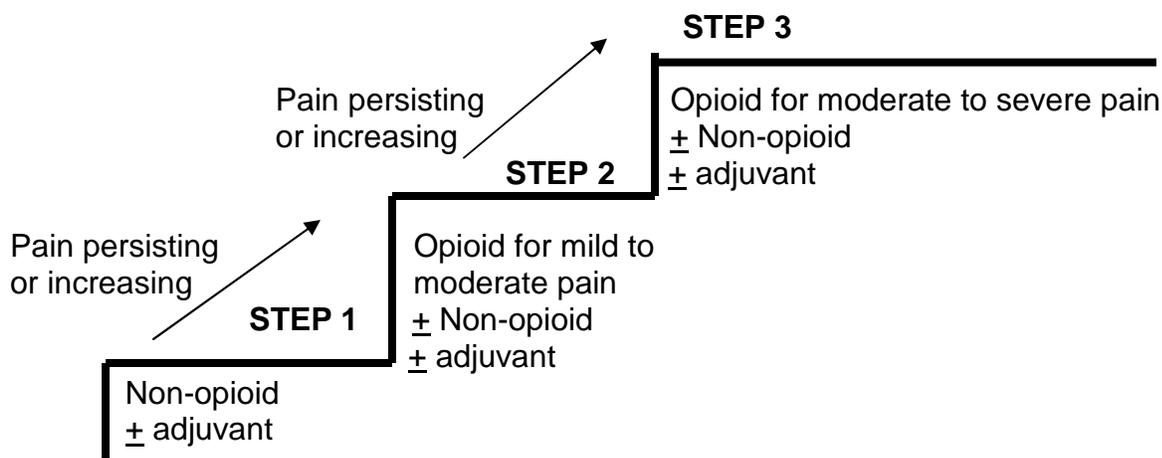
## APPENDIX C: Non-Pharmacological Methods of Pain Control

| Non-Pharmacological Method | Description/Rationale for Use   |
|----------------------------|---|
| Heat and Cold              | <p>Heat and cold have been used for centuries as a treatment for pain. Reasons for advocating for a trial of heat or cold:</p> <ul style="list-style-type: none"> <li>• it works well for some residents,</li> <li>• it works quickly,</li> <li>• adverse effects are virtually non-existent,</li> <li>• it can provide some residents/families with an important sense of control over the relief of pain.</li> </ul> <p><b>Rationale for treatment:</b><br/>Well-controlled research is lacking, however the premise is that applying heat to skin will increase blood flow and reduce neurotransmitters, which sensitize pain nerve fibres. Heat may compete for nerve transmission with pain and therefore, in the brain there is a perception of heat and a reduced perception of pain. Heat is considered most useful for chronic pain when there is no accompanying acute inflammation.</p> <p>Cold works through a similar pathway as heat, competing for nerve transmission. It creates numbness in the area of pain and may be especially helpful when the pain has a burning quality. Cold is useful for acute pain and where inflammation may be a contributing factor.</p> <p><b>Contraindications:</b><br/>Avoid use of heat in the following situations:</p> <ul style="list-style-type: none"> <li>• any area that is bleeding.</li> <li>• any injury/condition with decreased feeling, lack of sensation or areas of parathesia.</li> <li>• any injury within the first 24 hours.</li> <li>• if the resident is using any menthol-containing products (Vicks, Ben Gay, etc.).</li> <li>• within a site of radiation therapy while receiving radiation – may use on this area 5 days after completing treatment, provided that the skin is not flaky, red, or tender.</li> </ul> <p>Avoid use of cold in the following situations:</p> <ul style="list-style-type: none"> <li>• any area with poor circulation or sensation (diabetic feet).</li> <li>• within a site of radiation therapy while receiving radiation – may use on this area 5 days after completing treatment, provided that the skin is not flaky, red, or tender.</li> <li>• on a wound in the healing phase.</li> </ul> <p><b>Application of Heat or Cold:</b></p> <ul style="list-style-type: none"> <li>• Heat can be obtained from a variety of sources including heating pad, hot water bottle, and topical ointment.</li> <li>• Use low to medium setting to avoid burns. The application should produce a warm sensation rather than feel hot.</li> <li>• Placement is usually over painful site. When this is not possible (too painful, open wound) other options include: <ul style="list-style-type: none"> <li>-above the site.</li> <li>-below the site.</li> <li>-on the opposite side of the body (e.g., pain on right hip, place on left hip).</li> </ul> </li> <li>• Prevent direct contact with heat/cold source on the skin. Use layers of toweling between the heat/cold source and the skin.</li> <li>• The use of heat or cold with cognitively impaired residents should be monitored closely. When possible, sensation testing should be carried out over the application site prior to the first application.</li> <li>• Cold can be enhanced by using it in conjunction with menthol-containing products (e.g., A535 with ice bag over top).</li> </ul> |

| Non-Pharmacological Method | Description/Rationale for Use   |
|----------------------------|---|
| Heat and Cold              | <ul style="list-style-type: none"> <li>When using a topical ointment, test the skin with a small amount of product to check for allergic reaction prior to using it on the painful site.</li> </ul>   |
| Relaxation and Imagery     | <p>Relaxation may be appropriate for almost any type of pain with a goal of reducing muscle tension and anxiety. Residents who are already tense and in pain may benefit from simple relaxation centred on slow, deep breathing. Progressive muscle relaxation in which the resident uses isometric exercise to systematically relax muscles from head to foot may also be helpful.</p> <p>Lengthy relaxation techniques are enhanced by a quiet environment and having the resident in a comfortable, well-supported position. Listening to a taped relaxation session may help the resident to focus more easily, and become less distracted by their pain.</p> <p>Caution should be used in using relaxation and imagery techniques in residents who are either:</p> <ul style="list-style-type: none"> <li>confused,</li> <li>drowsy,</li> <li>have a poor understanding of the language of the relaxation therapist,</li> <li>has a previous history of significant psychiatric history, such as having hallucinations.</li> </ul> |
| Distraction                | <p>The idea is to divert the attention of the resident by actively involving him/her in the performance of a distracting task that is interesting and more pleasant than the painful procedure.</p>   |
| Other Therapies            | <p>Complementary therapies such as therapeutic touch, massage, reflexology, splint, Reiki and aromatherapy may be useful non-pharmacological adjuncts to pain management. These modalities should be administered by individuals with training in their application.</p> <p>Consider pressure relieving devices such as static air overlay or low-air-loss bed for residents at very high risk for pressure ulcers, has pressure ulcers, uncontrolled pain, or severe pain exacerbated by turning.</p> <p>The use of physiological and electrotherapy modalities such as TENS, ultrasound or laser therapy may be used as part of physiotherapy/occupational therapy management of musculoskeletal or chronic pain conditions. These modalities should only be applied by qualified professionals.</p>  |

## APPENDIX D: The Analgesic Ladder

### World Health Organization Analgesic Ladder



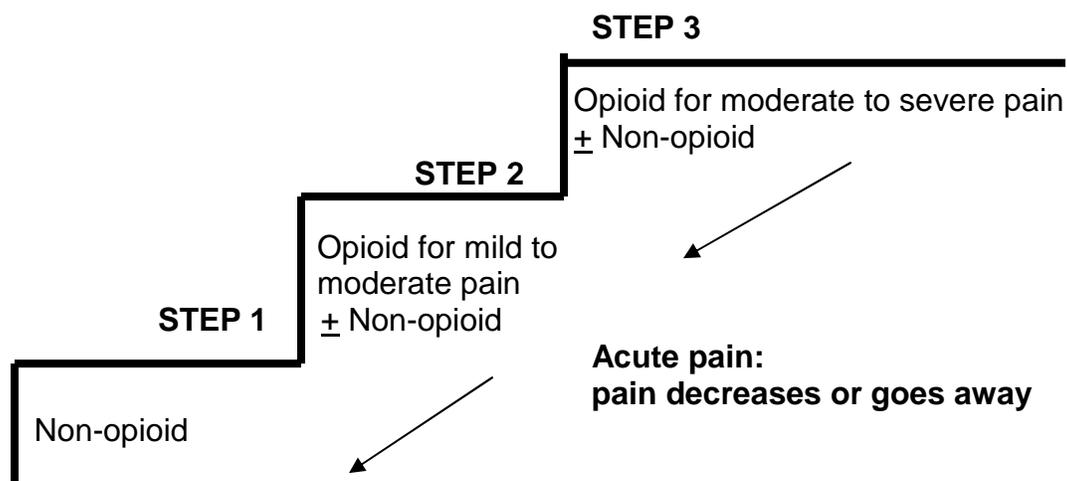
### Use of the WHO Analgesic Ladder

The WHO analgesic ladder is intended to be a guideline in structuring the use of analgesia in the pharmacological management of pain, and is not intended to be a rigid framework. The WHO approach to pain control may need to be combined with other treatment modalities. Evaluate the type and intensity of the pain, and then match the drug to the pain intensity and other characteristics.

The use of analgesia should start at the step of the analgesic ladder appropriate for the severity of pain. It is not necessary to initiate therapy at Step 1 if the person is experiencing moderate to severe pain, residents with severe pain should have therapy initiated at Step 3.

The use of the ladder is reversed in situation of acute pain, starting at Step 3 and moving to Step 1 analgesics as recovery occurs.

This figure shows a simple plan for acute pain management, which is an adaptation of the WHO Analgesic Ladder. As acute pain decreases, weaker analgesics are used.



#### References:

McQuay, H. (last updated 2002). Pain and its control. [On-line]. Available: <http://www.ir2.ox.ac.uk/bandolier/booth/painpag/wisdome/C13.html>

Registered Nurses' Association of Ontario. (2002). *Assessment and Management of Pain*. Toronto, Canada: Registered Nurses' Association of Ontario. [On-line]. Available: [www.rnao.org/bestpractices](http://www.rnao.org/bestpractices)

## APPENDIX E: Glossary of Terms

### **Breakthrough pain**

Intermittent exacerbations of pain that can occur spontaneously in relation to specific activity.

### **Mixed Pain**

Combination of Nociceptive and Neuropathic pain. For example, tumor invasion of pancreas with spread to and destruction of vertebra including spinal cord compression.

### **Neuropathic pain**

Pain that is initiated or caused by a primary lesion or dysfunction in the nervous system; involves the peripheral and/or the central nervous system.

### **Neuropathic pain described**

Neuropathic pain is usually described as sharp, burning, or shooting and is often associated with other symptoms such as numbness or tingling in the affected area.

Hyperalgesia over an area of skin –an increased painful response to a mildly painful stimulus (e.g. pinch, prick) or even slight pressure from clothing or light touch.

Usually constant and severe pain often precedes sensory and motor loss (e.g. spinal cord compression).

Often strange word descriptors e.g. “my feet feel wet all the time”.

### **Nociceptive pain**

Pain, which involves a noxious stimulus that is damaging normal tissues and the transmission of this stimulus in a normally functioning nervous system. Nociceptive pain is subcategorized into visceral, somatic and increased intracranial pressure.

**Visceral Pain:** Constant, dull, aching, poorly localized pain that has a gradual onset often felt at a distance from the origin (referred pain).

**Solid Viscera:** sharp and penetrating (e.g. liver and pancreas)

**Hollow Viscera:** diffuse or colicky pain (e.g. bowel and bladder)

**Somatic Pain:** Constant gnawing or aching, usually well-localized worse on movement or weight bearing if in pelvis, hips, femur, joints or spine. Deep somatic pain involves stimulation of nociceptors found in muscle, bone, joints and ligaments. Examples of somatic pain are bony metastases and skin ulcerations.

**Raised intracranial pressure:** e.g., brain tumors and meningeal carcinomatosis.

### **Non-pharmacological**

Refers to treatment of pain by non-drug methods, and includes rehabilitation strategies, physical modalities such as cold and massage, and cognitive behavioural approaches.

### **Unknown Pain**

Persistent pain, the cause of which cannot be determined by history and investigations. It may be described with all the current word descriptors. The resident is often not believed if investigations are inconclusive. It is usually under treated, can be debilitating and lifelong suffering may lead to depression.

**Additional questions or points to consider when asking about ADLs. Also included are possible “referrals to the professionals”.**

**Sleep and Rest**

- How often do you wake in the night and how many nights of the week?
- What is a good or bad night?
- What position do you sleep in?
- Do you use any special positioning devices?
- What do you do when the pain wakes you?
- Referrals: OT, PT, RN, Physician, Social Worker.

**Social Activities**

- Includes: hobbies, recreational activities, visiting family/friends etc.
- Referrals: OT, Social Worker, Volunteers.

**Appetite**

- Number and size of meals taken
- Did pain induced nausea?
- Did the nausea start when you started on the pain medication?
- Referrals: Dietitian, RN, Physician.

**Physical Activity and Mobility**

- Moving in bed, transfers to bed, chair toilet, stairs, walking, personal care etc.
- Referrals: OT, PT, RN.

**Emotions**

- Any change, as a result of the pain, and if so, is this significantly interfering with activities so that intervention would be helpful
- Referrals to Social Worker or Volunteer.

**Sexuality and Intimacy**

- Is the pain resulting in a significant reduction in desire for sexuality/intimacy or making the physical movement required too painful?
- Is this a concern for the resident?
- Referral to Social Worker, PT, OT, RN or Physician.