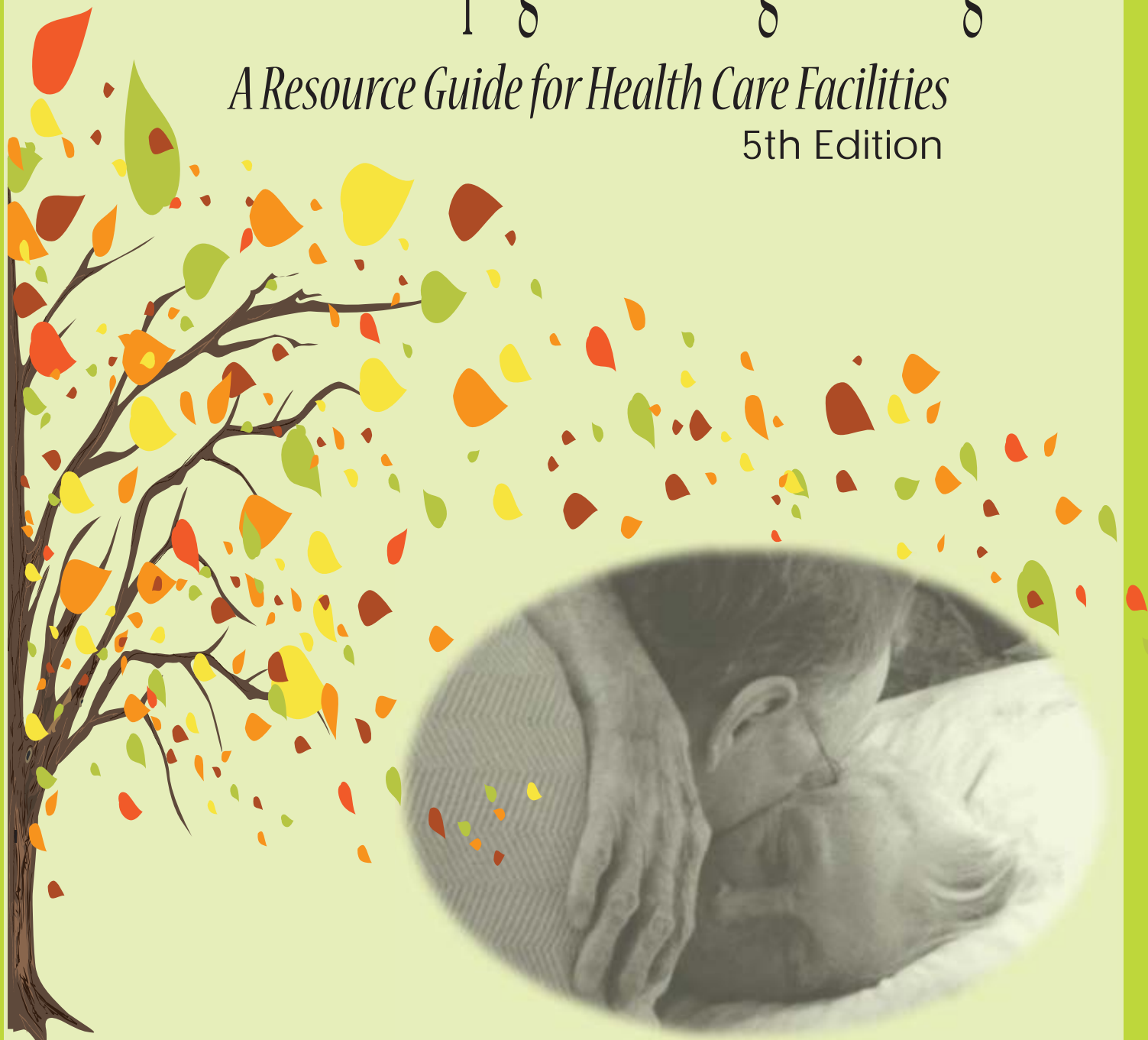


Guidelines for Developing a Pain Management Program

A Resource Guide for Health Care Facilities

5th Edition



**Guidelines for Developing a
Pain Management Program**

**A Resource for Long-Term Care Homes
And Health Care Facilities**

The revised and updated Fifth Edition February 2009

Table of Contents

INTRODUCTION	6
<i>Initial steps for developing a pain management program in a long term care home</i>	<i>6</i>
BUILDING A THERAPEUTIC RELATIONSHIP	7
PURPOSE.....	9
POLICY	9
PROCEDURE.....	9
1. <i>Assessment</i>	9
A. Pain Screening	9
Screening for the Presence of Pain	9
Conditions often associated with persistent pain.....	10
B. Pain Assessment.....	11
C. Pain Assessment Tools.....	11
D. Pain Classification.....	12
Nociceptive pain	13
Neuropathic pain.....	13
Mixed pain.....	13
Breakthrough pain	13
Incident pain	13
E. Total Pain Assessment.....	14
<i>Domains of Issues Associated With Illness and Bereavement</i>	<i>15</i>
2. <i>Information Sharing</i>	17
3. <i>Decision Making</i>	17
Non-pharmacological Management of Pain.....	17
Pharmacological Management of Pain.....	18
GUIDELINES FOR ANALGESIC DRUG ORDERS	19
4. <i>Care Planning</i>	20
5. <i>Care Delivery</i>	21
Registered Staff (RN/RPN): Pain Management Responsibilities	22
Knowledge of Basic Principles of Pain Management	22
Assessment, Decision Making & Care Planning	22
Interventions	23
Side Effects/Risk Management.....	23
Specific Roles and Responsibilities of Various Team Members.....	24
6. <i>Confirmation</i>	25
EVALUATION OF PAIN MANAGEMENT PROGRAM.....	25
PAIN MANAGEMENT PROGRAM ACTION PLAN	26
PAIN MANAGEMENT PROGRAM ACTION PLAN (CONT'D)	1
PHILOSOPHY OF PAIN MANAGEMENT LONG TERM CARE HOME (SAMPLE).....	28
ADMISSION PROTOCOL (SAMPLE).....	29
<i>References</i>	<i>30</i>
<i>Resources</i>	<i>31</i>
TO DOWNLOAD AN E-COPY OF THIS MANUAL GO TO:.....	32

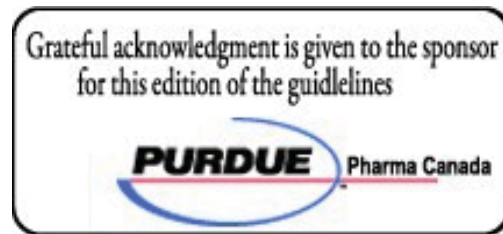
APPENDECIES:

Appendix A	RNAO Best Practice Guidelines References
Appendix B	LTCH GAP Analysis
Appendix C	PPS
Appendix D	Edmonton Symptom Assessment System Numerical Scale
Appendix E	Screening for Presence of Pain
Appendix F	Pain Assessment Tool
Appendix G	Brief Pain Inventory
Appendix H	PAINAD
Appendix I	Abbey Pain Scale
Appendix J	Doloplus Pain Scale

Appendix K	Pain Descriptors
Appendix L	FICA Spiritual Assessment Tool
Appendix M	Geriatric Depression Scale
Appendix N	Functional Assessment Staging In Alzheimer's Disease
Appendix O	SBAR Communication Tool
Appendix P	WHO Ladder
Appendix Q	Opioid Equianalgesic Dosing Chart
Appendix R	Opioids Frequently Used In Palliative Care
Appendix S	SISMP Canadian Safety Bulletin
Appendix T	Facial Grimace and Behavioural Checklist Flow Sheets
Appendix U	Pain Flow Record & Guidelines for Use

Disclaimer

The authors have taken care to confirm that the information provided herein is accurate and represents generally-accepted best practice. However new knowledge in pain management is regularly emerging via research, clinical and teaching experience. Therefore the editors and Purdue Pharma Canada are not responsible for errors or omissions of any kind or for any consequences from application of the information provided in this guideline, nor do they make any warranty to the currency, completeness or accuracy of the content. The reader accepts all risk of error and waives all rights of claim or action against the authors and Purdue Pharma Canada and acknowledges that the application of this information remains the professional responsibility of the individual practitioner.



Dedication

These guidelines are dedicated to the memory of **Dr. Linda Bowring**, geriatrician and palliative care physician whose passion, vision and expertise continues to influence interdisciplinary care team members in their quest to assist people and their families in the management of pain.

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Acknowledgement

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Note from the Authors



After years of working with providers in Long Term Care Homes (LTCH) and experiencing their passion and desire to provide excellent day-to-day care, we are pleased to provide this new evidence-based guideline for the development of a pain management program.

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Introduction

Pain management is an integral part of healthcare that needs to be championed by all staff members who provide care in LTCH and in health care settings across the continuum. Health care providers have an obligation to assist the affected person/family to better manage and cope with pain due to its high prevalence in the elderly population. Twenty to fifty percent of elderly in the community suffer from either recurrent or persistent pain and up to 80% of institutionalized elderly report at least one pain problem (Barkin, Barkin & Barkin, 2005).

This edition of the manual was developed in accordance with current evidence-based practice and best practice principles of pain management standards and incorporates the concepts from the manual, *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice*, March 2002 (available through www.chpca.net). In particular, the Registered Nurses Association of Ontario (RNAO) *Best Practice Guidelines (BPG) Assessment and Management of Pain* (2002) and *BPG Assessment and Management of Pain Supplement* (2007) are referenced throughout the document. A quick reference to the topics covered in this BPG can be found in [Appendix A](#). The BPG is available online at www.RNAO.org.

Please note:

To find the desired tools from the RNAO website go to www.RNAO.org Click on Best Practice Guidelines
Click on Clinical Practice Guidelines Program
Click on Guidelines and Fact Sheets
Scroll down to the assessment & management of pain document & click
The left side of the document provides various tabs; click on "pages"; this provides thumbnails of the pages of the entire document
Highlight the thumbnail of the desired page; may be viewed or printed

This manual provides suggested guidelines to assist in developing a pain management program in a LTCH and may be modified to reflect each unique situation. Other health care providers in acute care hospitals, psychiatric hospitals, and retirement homes have used the information in previous editions to implement pain management programs. To reflect the use of this manual for LTCH and other health care settings, the terms "resident" and "person" will be used interchangeably.

Initial steps for developing a pain management program in a long term care home

- commitment by the management team (administrator and director of care), in collaboration with the medical advisor, to address the issues related to pain management in the specific setting and to support the implementation of evidenced-based best practices
- establishment of an interdisciplinary pain management team
- evaluation of current pain management practices ([LTCH Gap Analysis - Appendix B](#))
- identification of opportunities for change in the clinical management of pain
- education for and support to staff
- assignment of staff responsibilities according to their knowledge and skills
- ongoing evaluation of the outcomes of pain management
- revision of pain management protocols to meet best practice standards

Building a Therapeutic Relationship

A pain management program that reflects best practice involves the development of a therapeutic relationship between skilled formal caregivers and the person/family over time. Each therapeutic encounter builds into a therapeutic relationship as changes in the person's/families' situation are addressed and chosen therapies are delivered. For some people, circumstances may require prolonged encounters or continuous care. According to *A Model to Guide Hospice Palliative Care* (Ferris, Balfour, Bowen, Farley, Hardwick, Lamontagne, et al., 2002), development of an effective therapeutic relationship depends on formal caregivers being

- skilled at effective communication
- skilled at facilitating care team formation and function
- skilled at effectively facilitating change in the illness experience

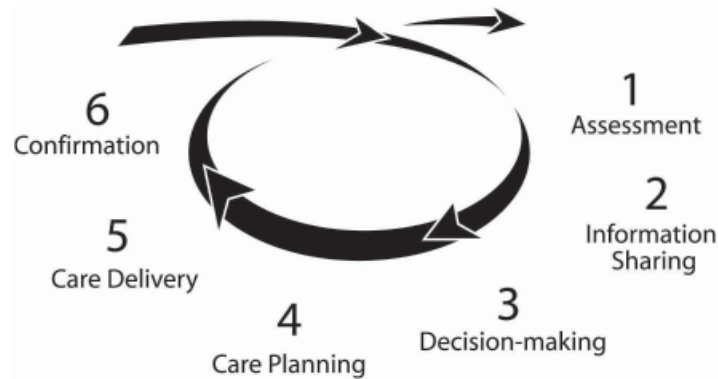
During each therapeutic encounter, the process for providing care involves six essential steps that guide the interaction between caregivers and the person and family (Ferris, et al., 2002):

- assessment
- information sharing
- decision making
- care planning
- care delivery
- confirmation

The following illustration provides more detailed information regarding the steps of therapeutic encounter.

NORMS OF PRACTICE *The Process of Providing Care*

Essential and Basic Steps During a Therapeutic Encounter



6. Confirmation

- Understanding
- Satisfaction
- Complexity
- Stress
- Concerns, other issues, questions
- Ability to participate in the plan of care

5. Care Delivery

- Careteam
 - Composition
 - Leadership, coordination, facilitation
 - Education, training
 - Support
- Consultation
- Setting of care
- Essential services
- Patient, family, extended network support
- Therapy delivery
 - Process
 - Storage, handling, disposal
 - Infection control
- Errors

4. Care Planning

- Setting of care
- Process to negotiate and develop plan of care that:
 - Addresses issues and opportunities, delivers chosen therapies
 - Includes plan for:
 - Dependents
 - Backup coverage
 - Respite care
 - Emergencies
 - Discharge planning
 - Bereavement care

3. Decision-making

- Capacity
- Goals for care
- Issue prioritization
- Therapeutic options with potential for benefit, risk, burden
- Treatment choices, consent
- Requests for:
 - withholding, withdrawing therapy
 - therapy with no potential for benefit
 - hastened death
- Surrogate decision-making
- Advance directives
- Conflict resolution

1. Assessment

- History of active and potential issues, opportunities for growth, associated expectations, needs, hopes, fears
- Examine with assessment scales, physical examination, laboratory, radiology, procedures

2. Information sharing

- Confidentiality limits
- Desire and readiness for information
- Process for sharing information
- Translation
- Reactions to information
- Understanding
- Desire for additional information

Pain Management Policy and Procedure

This Pain Management Policy and Procedure is based on the steps of the therapeutic encounter.

Purpose

To provide consistent assessment, management, monitoring and evaluation guidelines for the implementation of individualized pain management in order to facilitate optimal comfort, dignity and quality of life for all residents regardless of their level of functioning. An example of a tool that provides a framework for measuring progressive decline over the course of an illness is the Palliative Performance Scale ([PPS v2 Appendix C](#)).

Policy

Each resident at risk for pain, regardless of the level of cognition, should be screened for pain on admission, re-admission, during the provision of care or at least once a day. Residents experiencing unmanaged pain should have a comprehensive pain assessment completed and a care plan initiated. Based on this assessment, residents experiencing unmanaged pain should be treated immediately using non-pharmacological and/or pharmacological interventions to maximize function and promote quality of life. It is understood that pain may not be completely eliminated, but the goal is to develop and implement a safe comprehensive plan that maximizes improvement in function and quality of life.

Procedure

1. Assessment

A. Pain Screening

The interdisciplinary team will screen for pain using an appropriate tool considering factors such as age and level of cognition under the following circumstances:

- admission
- re-admission
- daily
- change in condition with onset of pain

The Edmonton Symptom Assessment System (ESAS) is an example of an assessment tool that screens for pain and other symptoms ([see Appendix D](#)).

Screening for the Presence of Pain

Health care providers have a responsibility to identify pain as an issue that requires further assessment and management. Therefore, all persons at risk for pain should be screened at least daily as well as during routine assessment by asking the person or family/care provider about the presence of pain, ache or discomfort. In the case of children, parents can be asked what words their child might use to describe pain. The child should also be observed for signs/behaviours indicative of pain. Frail elderly, non-verbal or non-cognizant individuals should be screened using a validated tool for that population if some of the following markers are present (Registered Nurses Association of Ontario, 2002):

- the person states pain is present
- there is a change in the person's condition
- the person is diagnosed with a chronic painful disease
- the person has a history of unexpressed chronic pain
- the person has taken pain-related medication within the last 72 hours
- the person exhibits distress-related behaviours (e.g. facial grimace)
- family, staff, or a volunteer indicate the presence of pain

[Refer to the Screening Tool for Pain \(Appendix E\)](#).

Conditions often associated with persistent pain

The words "persistent pain" more effectively describes constant unrelieved pain and therefore replaces the commonly used term "chronic pain". Most residents have predisposing factors for the development of persistent pain such as

- compression fractures of the spine
- old fractures
- osteoporosis
- degenerative joint disease
- immobility, contractures
- arthritis
- peripheral neuropathy (e.g. diabetes, post-herpetic neuralgia)
- angina
- claudication
- post stroke syndrome
- pressure ulcers
- gastrointestinal disorders
- renal conditions (e.g. bladder distension)
- headache
- post herpetic neuralgia (shingles)
- fibromyalgia
- cancer
- conditions related to treatment (e.g. post-op, cancer-related)

B. Pain Assessment

The Joint Commission on Accreditation of Healthcare Organizations Standards (2000) now advocates the assessment of pain as the fifth vital sign (Lynch, 2001; Merboth & Barnason, 2000). A comprehensive pain assessment should be completed and documented when unmanaged pain (persistent pain 4/10 or higher) has been identified. This assessment should be completed in collaboration with interdisciplinary team members, using assessment tools. At a minimum, a comprehensive pain assessment should include the following

- physical examination, relevant laboratory and diagnostic data
- medical history, including co-morbid medical conditions and allergies
- medication history including over-the-counter drugs
- etiology of pain, neuropathic versus nociceptive pain, pain-related symptoms, response to analgesia and management strategies for each category
- complementary therapies
- person's understanding of current illness and impact on the pain experience
- history of pain
- meaning of pain and distress caused by the pain (current and previous)
- coping responses to stress and pain
- effect on activities of daily living
- psychosocial and spiritual effects
- situational factors – culture, language, ethnic factors, economic effects of pain and treatment

C. Pain Assessment Tools

A comprehensive pain assessment tool assesses pain in the cognitizant and mildly to moderately cognitively impaired person and gathers information about

- location of pain (includes drawing of body for visual identification of location)
- intensity of pain (numerical indicator, facial grimace, verbal descriptor) and whether this pain is continuous, intermittent, new, old.
- quality of pain (descriptors such as *aching, throbbing, shooting, stabbing, gnawing, tingling, burning*)
- history of pain (diagnosis of painful disease processes, accidents, other painful experiences)
- effect on activities of daily living (e.g. appetite, sleep, rest, physical or social activities, dressing, toileting)
- effect on behaviour (e.g. pacing, calling out, withdrawal, resistance to care, not eating or sleeping)
- effect on quality of life (effect on happiness, contentment, fulfillment)
- other symptoms (constipation, nausea, fatigue, depression, shortness of breath, sore mouth)
- past pain experiences (including management methods and coping strategies used)
- family support person who would be available in time of pain crisis for history taking and advocating (may include friend, volunteer, neighbour)
- resident's goal for pain management (numerical indicator and/or verbal descriptor)
- non-pharmacological interventions tried and currently being used
- past and current medications, including over-the-counter drugs (how used, how often, dosage, outcomes)
- pain diagnosis or classification (neuropathic, nociceptive, mixed)
- prioritization of all issues related to pain that are identified in the assessment

Both **acute** and **persistent** pain can be assessed using a variety of tools such as

Tool	Citation	Description	Web Link	Appendix
Edmonton Symptom Assessment System (ESAS)	Bruera, Kuehn, Miller, Selmser & Macmillan, 1991	This self-administered tool is used to identify the intensity of nine symptoms including pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well being, and shortness of breath and to monitor the efficacy of interventions.	www.palliative.org/PC/ClinicalInfo/Assessmenttools/esas.pdf	D
Pain Assessment Tool	Registered Nurses Association of Ontario, 2002	This comprehensive tool can be used to assess location, aggravating and relieving factors, quality of pain, effects on activities of daily living, efficacy of current medications, related symptoms, and behaviours.	www.RNAO.org	F
Brief Pain Inventory (Short Form)	Cleeland, 1991; Pain Research Group, 1991	This two-page tool consists of nine questions that identify the person's experience with pain: the person's rating of pain intensity, interventions used, and the effect of pain on activities of daily living.	www.manderson.org/department/prg	G
Pain Assessment in Advanced Dementia (PAINAD)	Warden, & Hurley, 2003	This checklist was designed to measure pain behaviours in residents with advanced dementia.		H
Abbey Pain Tool	Abbey, Piller, DeBellis, Esterman, Parker, Giles, et al., 2004	This six-question tool assesses pain in the person with late-stage dementia who cannot verbalize.		I
DOLOPLUS 2 Scale	Lefebvre-Chapiro & the Doloplus group, 2001	This tool was developed for pain assessment in persons with advanced dementia. It evaluates somatic, psychomotor and psychosocial pain indicators.	Tutorial and tool available online: www.doloplus.com	J

D. Pain Classification

An integral part of assessment is the identification of the type of pain (classification) and aggravating factors (such as movement) since the management of pain may require more than one treatment intervention. The following table differentiates between acute and persistent pain (adapted from Coyle & Layman-Goldstein, 2001).

Acute Pain	Persistent Pain
<ul style="list-style-type: none"> • has a well defined pattern of onset • generally the cause can be identified • is accompanied by physiological signs of hyperactivity of the CNS such as increased BP and rapid pulse • has a precipitating cause which can usually be treated • tends to be time limited • responds well to analgesics 	<ul style="list-style-type: none"> • persists more than 3 months • adaptation of autonomic system occurs • objective signs of pain are not exhibited • contributes to fatigue, depression, insomnia, general despair, withdrawal and desire for death if poorly managed • is frequently unrecognized, untreated or under-treated

Pain is further classified into other categories.

Nociceptive pain

Pain caused by ongoing activation of pain fibres by a noxious stimulus resulting in inflammation. There are two sub-types

Somatic Pain: Pain of somatic origin (e.g. bone, muscle or soft tissue) may be described as dull, gnawing, boring, aching or cramping, and is easily localized.

Visceral Pain: Pain of visceral origin (e.g. gastrointestinal) is described as constant, deep, aching, squeezing or cramping pain. It is usually poorly localized or diffuse. It can be referred to the sacral, perineal, shoulder or back areas.

Neuropathic pain

Pain caused by the destruction, infiltration, compression or other changes of nerve tissue. Pain perception may continue in the absence of persistent, noxious stimulus. There are two sub-types often differentiated by the characteristics used to describe them

Dysesthetic or deafferent pain: Pain of dysesthetic or deafferent origin such as peripheral vascular disease or peripheral neuropathy is a constant pain that occasionally radiates and is often characterized by heat, burning, numbness or tingling over the area. Light pressure from non-painful stimuli (e.g. clothing or light touch) can produce severe pain.

Neuralgic Pain: Pain of a neuralgic origin such as post herpetic pain or sciatica is described as episodes of lancinating pain that can be sharp, shooting or electrical in nature that can follow nerve roots or dermatomes.

Mixed pain

Mixed pain contains both nociceptive and neuropathic components.

Breakthrough pain

Breakthrough pain is described as an intermittent flare of pain that exceeds the intensity of the baseline (constant) pain, and “breaks through” the baseline analgesia. Breakthrough pain and incident pain may occur in and classification of pain.

Incident pain

Incident pain is described as a severe transitory increase in pain of varying intensity that occurs suddenly in response to a trigger, such as toileting, repositioning, coughing, hiccups and or dressing changes.

For more information see [Appendix K, Details on Pain Descriptors](#)

E. Total Pain Assessment

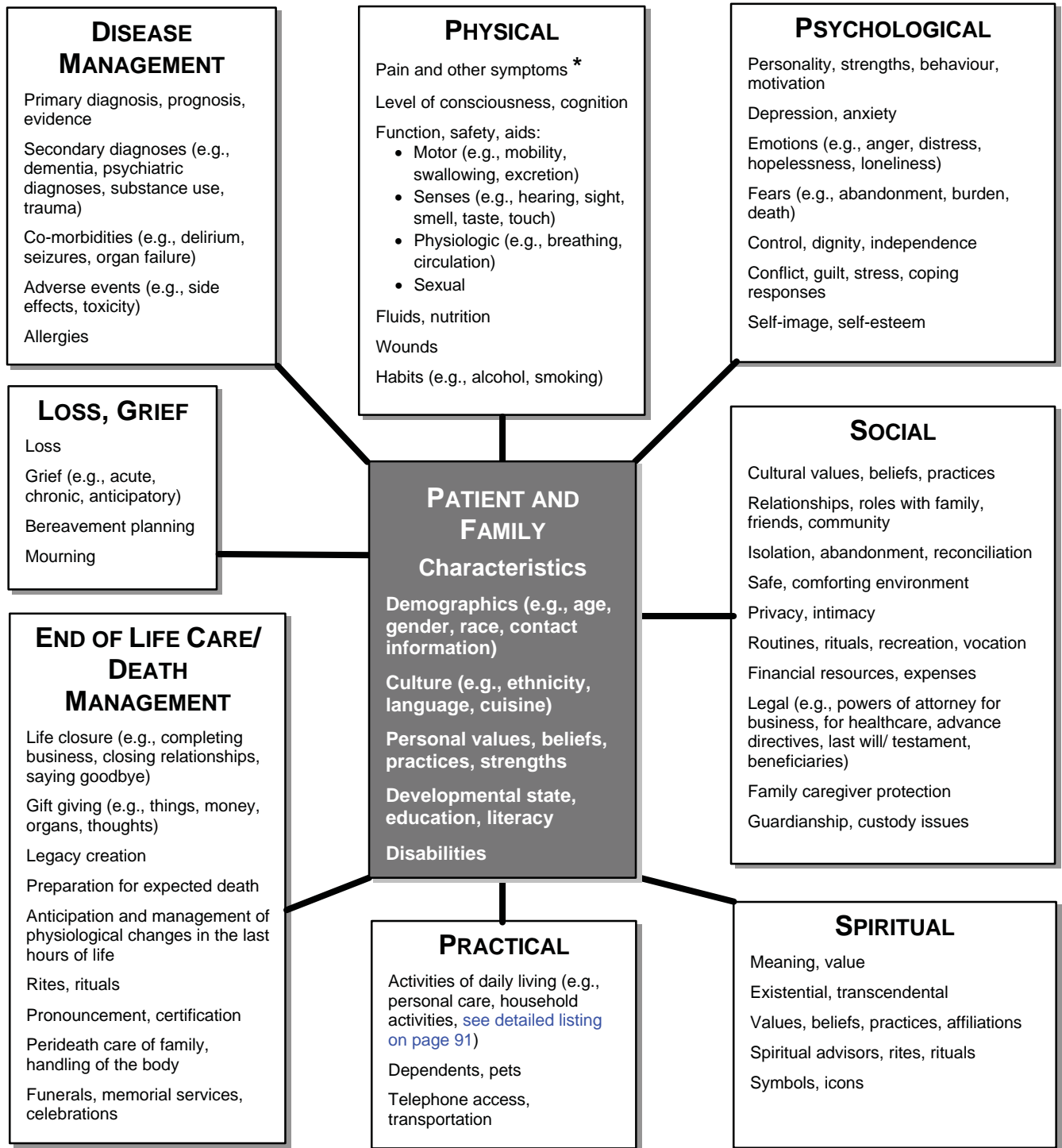
The person with acute, recurrent or persistent pain often experiences other types of suffering in addition to physical pain. According to *A Model to Guide Hospice Palliative Care* (Ferris et al., 2002, p.96), total pain is defined as “suffering related to, and the result of, the person’s physical, psychological, social, spiritual and practical state.”

Suspect total pain if

- significant psychosocial or spiritual issues are identified
- the person describes pain as all over, in absence of a physical cause for pain
- the pain appears to improve with socialization, physical activity or other distraction and increases when alone
- escalating doses of analgesics produce toxicity with little or no pain relief

To be effective at relieving suffering and improving quality of life, caregivers must be able to identify and respond to all the complex/multiple issues that patients and families may face. If one or more issues are missed, they can compound one another. This can lead to increased distress and further complications. The issues commonly faced by patients and families can be categorized into eight domains (Physical, Psychological, Social, Spiritual, Practical, Disease Management, Loss & Grief, End-of-Life Care/Death Management). Each is of equal importance. The following figure from the *Model to Guide Hospice Palliative Care* (Ferris et al., 2002) outlines the domains and examples of issues in each.

Domains of Issues Associated With Illness and Bereavement



* Other common symptoms include, but are not limited to:

Cardio-respiratory: breathlessness, cough, edema, hiccups, apnea, agonal breathing patterns

Gastrointestinal: nausea, vomiting, constipation, obstipation, bowel obstruction, diarrhea, bloating, dysphagia, dyspepsia

Oral conditions: dry mouth, mucositis

Skin conditions: dry skin, nodules, pruritus, rashes

General: agitation, anorexia, cachexia, fatigue, weakness, bleeding, drowsiness, effusions (pleural, peritoneal), fever/chills, incontinence, insomnia, lymphoedema, myoclonus, odor, prolapse, sweats, syncope, vertigo

Several tools are available to identify issues in other domains that may affect the person's pain experience. These include but are not limited to the following

Tool	Citation	Description	Web Address	Appendix
Edmonton Symptom Assessment System (ESAS)	Bruera et al., 1991	This self-administered tool is used to assess nine symptoms including pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well being, and shortness of breath.	www.palliative.org./PC/ClinicalInfo/Assessmenttools/esas.pdf	D
Palliative Performance Scale version 2 (PPSv2)	Anderson, Downing, Hill, Casorso & Lerch, 1996	This is a reliable and valid tool that provides a framework for measuring progressive decline over the course of illness. It serves as a communication tool for the interdisciplinary care team and can act as a workload measurement tool.	www.npcrc.org/usr_doc/adhoc/functionalstatus	C
Faith, Importance, Community, Address (FICA)	Puchalski, 1999	This tool is used to consider four aspects of the spiritual domain that may influence the person's pain experience. The assessment is remembered by the acronym FICA, representing the four domains it touches on: Faith, Importance, Community and Address.	www2.edc.org/lastacts/archives/archivesNov99/assesstool.asp	L
Geriatric Depression Scale Short Form	Sheikh & Yesavage, 1986	This fifteen-question mood scale screens for depression in older adults.	www.stanford.edu/~yesavage/GDS.english.short.html	M
Functional Assessment Staging of Alzheimer's Disease (FAST)	Reisberg, B. 1988	This tool assists the care provider in understanding the stage of Alzheimer's disease that the person is in and guides their approach to that individual's unique deficits and needs.	www.bigtreemurphy.com/Reisberg%20FAST.htm	N

2. Information Sharing

A discussion will occur with the resident regarding treatment options in such a way that

- privacy and confidentiality limits are maintained
- information is provided in a language and manner that is understandable
- the resident's readiness to receive information is considered
- myths and barriers about pain management are addressed
- the extent of understanding and need for additional information is noted
- the plan of care is discussed
- a goal for pain management is agreed upon

Other people, including the resident's family, may be included in these discussions with the resident's consent. If the resident is incapable, this discussion will take place with the resident's substitute decision maker (SDM). In this case, others may be included in these discussions with the SDM's consent.

The health care provider shares the information gathered with the interdisciplinary team members so that all team members provide consistent interventions, information and reinforcement of the written plan of care for pain management.

Effective communication with the physician is essential as it will affect the pain management regimen for the individual resident. The following measures should be considered before contacting the most responsible physician:

- completing a comprehensive pain assessment
- knowing the goals of care for the person
- knowing the person's PPS
- having the person complete the ESAS (if he/she is able)
- knowing your agency/facility policies and standards
- completing the Situation Background Assessment Recommendation (SBAR) Report to physician tool ([Appendix O](#))

3. Decision Making

Important: Consent to treatment is obtained from the capable and informed resident or from the SDM if the resident is deemed incapable. The interdisciplinary team will support the resident/SDM in setting goals and selecting treatment options for pain management by

- sharing the potential risks/benefits of treatment options
- discussing requests for withholding, withdrawing therapy
- understanding the resident's wishes
- considering the resident's stage of PPS or FAST score when implementing care

Non-pharmacological Management of Pain

Non-pharmacological interventions should be combined with pharmacological interventions to achieve effective pain management. Non-pharmacological interventions should not be used as a substitute for adequate pharmacological management. There are many choices of non-pharmacological interventions that address the physical, psychosocial, spiritual and emotional components of the pain experience. Some team members who could support the resident are the spiritual care provider, the social worker and/or the physical therapist. Some residents may want to pay privately for music therapy or other interventions not provided in their LTCH. Policies need to be developed to address these options.

The choice of intervention should be based on the person's preference and the goal of treatment while considering any potential contraindications. Some examples of non-pharmacological interventions are listed below

- superficial heat or cold
- massage
- relaxation
- imagery
- exercise
- music
- pressure or vibration
- psychosocial interventions to facilitate coping
- cognitive-behavioural strategies plus multidisciplinary rehabilitative approaches
- psycho-educational interventions

Pharmacological Management of Pain

In terms of pharmacological interventions, the decision-making process involves

- choosing the appropriate analgesic based on the pain type, the etiology of the pain, the condition of the person, concurrent medical conditions, response to prior or present medications, cost to the person
- choosing the appropriate analgesic where the potential benefits outweigh the potential risks
- choosing the safest possible medication and route
- choosing an appropriate starting dose based on the severity of the pain, the age and condition of the person, the particular properties of the medication
- determining the particular drug preparation to use based on the severity of the pain and need for rapid titration, ease of administration ([WHO Analgesic Ladder, Appendix P](#))
- choosing the appropriate route of administration based on the needs of the person, skill of the caregivers and ease of administration
- anticipating and managing common side effects
- gaining consensus among the team, including the person and family, to ensure compliance

“Opioid” versus “narcotic” versus “opiate

Opioid is the term used to describe the class of medications that includes analgesics such as morphine, oxycodone, hydromorphone, tramadol, fentanyl and codeine. Narcotic is a legal term for those opioids that are scheduled and listed as controlled substances under the Narcotic Control Act. Opioid includes all analgesics, natural and synthetic, and is used instead of the term “opiates” which refers to those analgesics produced from a natural poppy alkaloid.

Guidelines for Analgesic Drug Orders

The following criteria will serve as a guide for evaluating analgesic orders to ensure appropriate use of analgesics and adjuvant therapies based upon the resident's completed pain assessment.

1. The interdisciplinary team will ensure that the selection of analgesics is individualized to the resident, taking into account the type of pain, intensity, potential for analgesic toxicity, general condition of the resident and response to prior or present medications.
2. Drugs used for pain management are based upon severity of pain, and the World Health Organization (WHO) 3-step ladder guideline (RNAO, 2002). ([Appendix R](#) and available online at www.RNAO.org).
 - Acetaminophen is used for relieving mild musculoskeletal pain. The maximum dose for the elderly for chronic use should generally not exceed 2.6 grams per 24-hour period. Use non-steroidal, anti-inflammatory drugs (NSAIDs) with caution (Jovey, 2002).
 - Opioid analgesics are used for relieving moderate to severe pain. Tramadol may be a better choice than codeine for some elderly, as it tends to be less constipating than codeine.
 - Darvon® and Demerol® and Talwin® are avoided due to weak analgesic effect and potential toxicity (*ISMP Canada Safety Bulletin*, Volume 4, Issue 8, August 2004).
3. The **oral** route is the first choice for the administration of analgesic medications. If the resident is unable to take oral medications, buccal, sublingual, rectal, and transdermal routes are considered before parenteral routes. Once pain is stabilized, sustained release oral, rectal or transdermal analgesics may be beneficial. Transdermal opioids like fentanyl should not be used in opioid-naïve patients (Opioid Equianalgesic Dosing Chart, Appendix Q and Opioid Analgesics Used Frequently in Palliative Care, [Appendix R](#); also available online at www.palliativecareswo.ca).
4. Opioids for incident pain should be prescribed on an as-needed basis only, rather than daily or "around the clock".
5. To optimize pain relief for continuous pain, analgesics should be administered on an "around-the-clock" basis according to the duration of action of the prescribed analgesic.
6. Short-acting opioids used on an "around the clock" basis are usually ordered at every 4-hour intervals. However, in renal impairment, increasing the dosing interval may be indicated because reduced clearance of metabolites may occur.
7. Breakthrough pain can occur with acute and/or persistent pain. Immediate release, short-acting preparations allow for management of breakthrough pain and careful titration of opioids to individualize pain management. It is most effective to use the same opioid for breakthrough pain as that being given for "around the clock" dosing.
8. Breakthrough doses of analgesic should be administered on an "as needed" basis according to the peak effect of the drug (po/pr = q1h; SC/IM = q30 min; IV = q 10 – 15 min.) (RNAO, 2002).
9. Long-acting oral analgesic agents are generally not effective for the management of acute episodic pain. Immediate release agents may be more effective.
10. Current best practice suggests that only one long-acting opioid at a given time is ordered for management of continuous moderate to severe pain. Examples of long-acting oral opioids are MS Contin®, M-Eslon®, Kadian®, OxyContin®, Hydromorph Contin®, Codeine Contin®, Tramacet®, and Zytram XL®. The Ran-fentanyl® reservoir or Ratio Fentanyl® matrix transdermal patches are slow-release forms of a rapidly acting analgesic. The fentanyl transdermal patch should not be used in the opioid-naïve person. Before initiating the 25-ug/hr patch, the manufacturer recommends that the person be on the equivalent of a total of 60 mg of oral morphine per day for 6 consecutive days. ([Appendix S, ISMP Canadian Safety Bulletin](#)) *Reproduced with permission from ISMP Canada.*

11. Side effects of opioids, such as nausea, vomiting, constipation and drowsiness, should be recognized and treated.
12. Signs of opioid toxicity, such as confusion, hallucinations, myoclonus, and seizures, should be recognized and treated.
13. Adjuvant analgesics are drugs that have primary indications other than pain but that do have analgesic properties. They may be used alone if the pain is mild but more commonly are used in combination with opioids if pain is moderate to severe. (Pallium Palliative Pocketbook) For instance, desipramine or gabapentin may be used along with an opioid to treat neuropathic pain. Begin with the lowest possible dose of adjuvant and increase slowly because of the potential for toxicity of many agents in the elderly.
14. Side effects of adjuvants should be recognized and treated, being aware that they may potentiate opioid side effects. For instance, adding amitriptyline to an opioid may increase the potential for constipation or sedation.
15. A plan should be in place for pharmacological and/or non-pharmacological interventions prior to activities that are reported to cause or increase pain (e.g. pain management interventions prior to a dressing change).
16. Darvon® and Demerol® and Talwin® are avoided due to weak analgesic effect and potential toxicity (e.g. metabolites) (*ISMP Canada Safety Bulletin*, Volume 4, Issue 8, August 2004).
17. After repetitive dosing, morphine can become more potent because of the metabolite known as Morphine-6 glucuronide. Morphine-3 glucuronide is also a metabolite of morphine. It is not an analgesic like Morphine-6, but it is a stimulant, and when it accumulates, the resident *may* experience symptoms of opioid toxicity such as myoclonus, hallucinations and seizures. An older person or anyone with compromised renal function will tolerate morphine poorly because of the accumulation of these metabolites (Jovey, 2002). In this case, switching to hydromorphone or oxycodone or fentanyl should be considered.

4. Care Planning

The interdisciplinary team establishes a plan of care for pain management that is consistent with the resident's goals. Healthcare providers are ethically and legally obligated to advocate for pain management and should develop a plan of care that

- recognizes that pain is subjective and multidimensional
- addresses issues identified by the resident/family (tools such as ESAS can be helpful)
- takes into account the cultural values, beliefs and practices of the resident/family
- takes into account current and future treatment plans including current health status (PPSv2) and co-morbid conditions
- treats unrelieved acute pain to avoid the possibility of developing persistent pain
- uses non-pharmacological interventions
- uses analgesics that optimize quality of life and facilitate routine activities such as ambulation and activities of daily living
- anticipates and manages pain that may occur during procedures such as dressing changes and rehabilitation activities
- considers referral to a external pain management expert
- delivers chosen therapies according to best practice standards
- evaluates all interventions ([see Section 6: Confirmation](#))

5. Care Delivery

Knowledge, technical skills and judgement by various members of the health care team are key to the successful delivery of the interventions of the pain management plan. Policies within each LTCH must be developed that clearly outline the process and responsibilities for delivering care identified in the care plan. Pain management responsibilities for registered staff; personal support workers and all formal caregivers must be clearly articulated, along with the role of the patient and family.

According to the *A Model to Guide Hospice Palliative Care* (Ferris et al., 2002), formal caregivers are members of an organization and accountable to defined norms of conduct and practice. They may be professionals, support workers or volunteers. They are sometimes called "providers."

Standards of care need to be developed at each facility that define staff responsibilities and expected resident outcomes. For More information refer to (*Canadian Hospice Palliative Care Association, standards for pain management, and the Registered Nurses Association of Ontario, Assessment and Management of Pain, Best Practice Guidelines*). The registered staff pain management responsibilities that follow are an example only, not an exhaustive list.

Registered Staff (RN/RPN): Pain Management Responsibilities

Registered nursing staff, according to the facility policies is responsible for the following

Knowledge of Basic Principles of Pain Management

- the domains of issues associated with illness and bereavement
- the essential and basic steps during a therapeutic encounter
- the person with the pain experience – not the health care provider, family, or friend – is the authority on the pain
- the complexity of the “total” pain experience, including the physical, psychosocial, emotional and spiritual components
- the major classifications of pain: acute, persistent, nociceptive, neuropathic, mixed, incident and breakthrough; the differences in their quality, presentation, and management
- knowledge of incident and breakthrough pain
- the impact of inadequately treated pain on physiological function, psychological status and quality of life
- the major barriers to adequate pain management which include
 - the myth that pain is a normal part of aging
 - fear of addiction to pain medications (resident/family/staff)
 - fear of developing tolerance to pain medications
 - the assumption that pain must be endured
 - fear of side effects from pain medications such as confusion, sedation, respiratory depression, constipation, nausea and vomiting
 - concern by the person/family for “bothering” the staff
- the different ways people may describe pain (e.g. “not feeling myself”, “tingling in my legs”)
- the issues that impact on pain management (e.g. physician reluctance to prescribe because of incomplete assessment information and lack of timely access to controlled substances for escalating pain problems)
- the issues around medical directives, informed consent, right of refusal of treatment and the personal right of choice
- professional strengths and weaknesses related to knowledge of pain management
- use of the PPS, ESAS, FAST and other assessment tools

Assessment, Decision Making & Care Planning

1. Using a standard pain assessment tool to
 - document location, intensity, quality, pattern, (e.g. radiating, intermittent or constant), alleviating and aggravating factors, medication history, response to past treatments, and other relevant factors such as the person’s lifestyle, impact of the pain on the person’s life (activities of daily living, sleep, rest, appetite, nutritional status, and mobility)
 - provide accurate, objective and timely documentation of the pain assessment in the person’s health record, according to the agency/institution policy and based on assessed needs and goals of the person
 - demonstrate the choice and implement the use of appropriate tools for assessment in cognizant and mildly, moderately or severely impaired persons, based on assessment data
2. Monitoring and documenting efficacy of medication and treatment
 - at least every four hours or after every medication change or according to agency/institution policy
 - on a more frequent basis if person’s pain goal is not met or adverse effects are present

Sample monitoring tools

- **Facial Grimace & Behaviour Checklist Flow Charts** (RNAO, 2002) The Facial Grimace Scale (incorporating the 0-10 numerical scale) is a monitoring tool used to document the intensity of pain for the cognizant person and those with mild cognitive impairment. The Behaviour Checklist identifies and monitors the presence of pain for those with moderate to severe cognitive impairment using ten pain behaviour indicators ([Appendix T](#))
- **Pain Flow Record and Guidelines for Use** ([Appendix U](#)) An outcome measurement tool that tracks individual pain scores

3. Developing an interdisciplinary care plan that addresses the needs and goals of a person with pain

Interventions

1. Knowing the three major classes of analgesic drugs (non-opioids, opioids, adjuvant medications) and their appropriate use either alone or in combination
2. Using an equianalgesic dosing table to convert accurately from one opioid to another and/or from one route to another, in order to confirm safety and accuracy of medical orders
3. Knowing the routes of opioid administration (oral, rectal, sublingual, transdermal, subcutaneous) and the rationale for their use
4. Demonstrating and appropriately applying non-pharmacological interventions in clinical practice such as positioning, distraction, relaxation, heat and cold
5. Using the principles outlined in the *Guidelines for Analgesic Drug Orders* to ensure optimal pain management especially
 - matching the choice of analgesic to the intensity and type of pain
 - matching the frequency of administration to the duration of the medication's effect
 - the importance of around-the-clock dosing for constant pain
 - the use of breakthrough medications and calculation of doses
 - simplifying analgesic modality and dosage schedule with most benefit for the person (e.g. use of the oral route before parenteral routes are used; trial of opioids and adjuvant medications before pumps and anaesthetic procedures are used)
6. Serving in a leadership and mentor role and working with other disciplines in the person's pain management plan of care
7. Including the person/family/SDM in all aspects of pain management, especially through ongoing education about pain, assessment, treatments and the common barriers to adequate management
8. Knowing and applying the facility's policies and procedures related to medical directives, informed consent and the right of the person/SDM to choose or refuse treatment
9. Demonstrating knowledge about various medication delivery systems
10. Relaying information with confidence to the physician through preparation and planning, relating all pertinent assessment data in a clear, complete, concise manner; asking for feedback; and identifying appropriate orders
11. Documenting and communicating to all staff the plan of care related to the orders received, including goals and rationale for use of non-pharmacologic interventions, analgesic and adjuvant medication with potential side effects and expected outcomes
12. Recognizing the need and advocating for referral to a pain management consultant or other specialized care consultants (e.g., physiotherapy, occupational therapy, wound care specialist)

Side Effects/Risk Management

1. Knowing and putting into practice the basic approaches to the management of potential side effects of opioids such as
 - sedation
 - constipation
 - nausea and vomiting
 - itching
 - respiratory depression
 - potential drug interactions
2. Defining tolerance, physical dependence and addiction, and clearly describing the differences among them
3. Knowing the major risks associated with the use of non-steroidal anti inflammatory drugs (NSAIDs) and that some of these may occur more commonly in the elderly, including
 - gastric irritation and bleeding

- renal failure
 - diminished platelet function
- Knowing when NSAIDS can be used for the elderly as adjuvant pain medication

4. Stating the dose limitations of acetaminophen related to its potential toxicity

5. Recognizing the common side effects of adjuvant analgesics such as
- for tricyclic antidepressants: dry mouth, constipation, urinary retention, orthostatic hypotension, drowsiness
 - for anticonvulsants: dose-related bone marrow suppression (with carbamazepine)
 - for corticosteroids: Cushing's Syndrome, hyperglycaemia, weight gain, mood changes

6. Educating and supporting the resident and family regarding pain management

Specific Roles and Responsibilities of Various Team Members

As mentioned at the beginning of this section, administration, patients, family, and all members of the formal care team have roles and responsibilities to support the pain management program. The following table provides examples for a few key members of the team.

Team Members	Roles and Responsibilities
Director of Care or Designate	<ul style="list-style-type: none"> • Collects data, analyzes statistics, identifies trends, evaluates outcomes, and presents quarterly statistics to an interdisciplinary committee • Seeks advice from experts to support team decisions • Coordinates education processes relating to pain management
Nursing RN, RPN (according to scope of practice in current position)	<ul style="list-style-type: none"> • Facilitates the implementation of pain management procedures for each resident • Conducts and documents a pain assessment <ul style="list-style-type: none"> • on admission • on re-admission • quarterly • on initiation of a pain medication or prn analgesic • when a resident exhibits behaviours that may herald the onset of pain • when a change in condition occurs with onset of pain • when a resident states pain severity is 4/10 or greater • upon the diagnosis of a painful disease • when there is a history of unexpressed pain • when a resident receives pain-related medication for more than 72 hours • when a resident exhibits distress-related behaviours or grimaces • when a resident/family/staff/volunteer indicates pain is present • Initiates a pain management flow record when a scheduled pain medication does not relieve the pain or when pain persists regardless of interventions • Communicates assessment information to the physician using communication tool. • Makes referrals to interdisciplinary team members • Provides education to family/resident/staff about pain management • Evaluates plan of care as necessary
Physician	<ul style="list-style-type: none"> • Provides pertinent information regarding medical history that may impact pain diagnosis and treatment • Supports/guides the development of a plan of care that addresses the identified pain issues • Collaborates with interdisciplinary team members to monitor all interventions and outcomes

Team Members	Roles and Responsibilities
	<ul style="list-style-type: none"> Provides education to patient/family and staff about pain management
Pharmacist	<ul style="list-style-type: none"> Dispenses and monitors drug usage Provides education to staff regarding safe and current pharmacological best practices Is available as a resource (e.g. to assist with opioid conversions, to provide evidence based research articles) Participates in quarterly and annual resident care reviews
Personal Support Worker/Health Care Aide	<ul style="list-style-type: none"> Recognizes and reports resident verbalizations and behaviours indicative of discomfort Reports decrease in any of the following: physical or social activity, energy, appetite, continence pattern or hours of sleep Notifies RN/RPN 1 hour before bathing, dressing and turning if these activities regularly cause the resident to experience pain Observes and reports outcomes following analgesic administration
Occupational Therapists/ Physiotherapists (OT/PT)	<ul style="list-style-type: none"> Assesses resident for pain or any factors that may contribute to pain (e.g. seating assessment if resident is in a wheelchair) 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 Evaluates and advises the interdisciplinary team of the impact of pain on mobility and ADL status and recommends assistive mobility equipment and adaptive aids Educates resident, family and staff on the use of equipment/devices/aids Evaluates and reassesses resident status
OT Assistant/PT Assistant/Rehabilitation Assistant	<ul style="list-style-type: none"> Carries out assigned treatments relating to adjunct pain-relieving modalities, mobility and ADL status Monitors resident responses and reports responses to interdisciplinary team Monitors/inspects assistive mobility equipment, adaptive aids, and joint support/positioning devices on a regular basis

6. Confirmation

Once a comprehensive pain assessment is completed and pain management interventions are provided, monitoring tools are used to determine whether the pain management strategies initiated by the interdisciplinary health care team are effective in managing the resident's pain in order that individual goals are achieved. The level of discomfort, the intervention and the degree of relief obtained are documented until the goal for pain management is achieved. ([Appendix T and U](#))

Evaluation of Pain Management Program

Continuous quality improvement is a critical component of the commitment to pain management. Auditing pain management interventions and outcomes through the use of chart reviews and evidence-based tools promotes practice change and the ongoing improvement of pain management.

The following pages contain sample documents to facilitate the implementation of an individualized pain management program.

Pain Management Program Action Plan

Task	How	Who	Target Date	Outcome
Form interdisciplinary work group with support of administration and physician.				
Assess current pain management practices using the LTCH Gap Analysis Form				
Develop philosophy, policies and procedures based on best practice guidelines for pain management.				
Adopt common tools for assessing pain (see the Appendices).				
Develop a method for documentation that measures outcomes of all interventions.				
Provide opioid equianalgesic dosing tables and a pharmacological reference book and/or reliable pharmacological reference site on the internet to MDs, RNs and RPNs on each nursing unit.				

Pain Management Program Action Plan (cont'd)

Task	How	Who	Target Date	Outcome
Provide education for all staff according to their scope of practice at orientation, as issues arise and yearly.				
Provide information on non-pharmacological interventions.				
Develop an interdisciplinary pain management team and identify a pain and symptom resource nurse who is supported by the management team.				
Include a philosophy of pain management statement as part of the information package for new residents/families				
Establish accountability within the organization for pain management by adopting <i>RNAO Best Practice Guideline - Assessment and Management of Pain</i> (2002) and the <i>RNAO Assessment and Management of Pain Supplement</i> (2007).				
Develop and/or adopt an evidence-based evaluation tool for the pain management program.				

Philosophy of Pain Management Long Term Care Home (Sample)

We believe pain relief is the right of each person as it facilitates optimal comfort, functioning and enhances quality of life.

The management of pain is integral to the mission of (Name of Long Term Care Home/Facility)

The formal interdisciplinary care team will provide comprehensive care, which includes the recognition, assessment and management of pain, following current evidenced-based best practice guidelines. Optimum pain relief requires individualized treatment and acknowledgement of its multidimensional nature (physical, psychological, social, and spiritual).

Comprehensive pain management is achieved through the effective use of an individualized pain management care plan using both non-pharmacological and pharmacological interventions.

In the event of complex pain management issues, expert external pain management resources are used.

Admission Protocol (Sample)

Purpose

To ensure that the resident/family understands the commitment of the long term care home to provide optimum pain relief to every person based on evidenced-based best practices.

Procedure on admission

1. The nurse will inform the resident/family/substitute decision maker (SDM) of the long term care-home's pain management philosophy.
2. The nurse will include the following pain assessment principles in the resident/family/SDM education
 - reports of pain are believed
 - validated tools are used to assess and monitor pain (e.g. Edmonton Symptom Assessment System)
 - health care professionals will respond promptly to reports of pain and are responsible for the assessment and management of pain
 - the resident, family and SDM are part of the care team and encouraged to report unrelieved pain
 - total freedom from pain is not always possible
 - if pain is present, the resident/family/SDM will be informed of the use of pain intensity scales such as the Numerical Scale (RNAO, 2002), the Verbal Descriptive Scale (RNAO, 2002), Facial Grimace Scale (RNAO, 2002) and Behaviour Checklist Flowchart (RNAO, 2002)
3. If pain is present on admission, the nurse will inform the resident/family/SDM about the pain assessment process and advise that, following assessment, appropriate non-pharmacological and pharmacological interventions will be offered after consultation with the formal care team to ensure that the pain is being addressed.

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Resources

County Specific Tools

Lambton / Kent / Oxford / Elgin

Appendices

RNAO Best Practice Guidelines References

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PRACTICE RECOMMENDATION

ASSESSMENT

	RECOMMENDATION	PAGE
Screen for Pain	1	10, S3
Parameters of Pain Assessment	2, 3, 4, 5,	10, 11, S3 - 4
Comprehensive Pain Assessment	6	11, S4
Reassessment and Ongoing Assessment of Pain	7, 8, 9	12, S5
Documentation of Pain Assessment	10, 11, 12	13, S5 - 6
Communicating Findings of a Pain Assessment	13, 14, 15, 16, 17, 18	14, S6 - 7

MANAGEMENT

Establishing A Plan for Pain Management	19, 20	15, S7
---	--------	--------

Pharmacological Management of Pain

Select Appropriate Analgesics	21, 22, 23, 24, 25, 26, 27, 28, 29	15-17, S8 - 10
Optimizing Pain Relief with Opioids	30, 31, 32, 33, 34, 35, 36	18-20, S10 - 12
Monitoring for Safety and Efficacy	37, 38, 39, 40	20 - 21, S12
Anticipate and Prevent Common Side Effects of Opioids	41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53	21 - 22, S13 - 15
Anticipate and Prevent Procedural Pain	54, 55, 56	23, S15
Patient and Family Education	57, 58, 59	23, S16
Effective Documentation	60, 61	24, S16 - 17

Non-Pharmacological Management of Pain

Non-Pharmacological Management of Pain	62, 63, 64, 65, 66	24, S17
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EDUCATION RECOMMENDATIONS

Recommendations	67, 68, 69, 70	25, S18
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ORGANIZATION AND POLICY RECOMMENDATIONS

Pain Management Long Term Care Home Gap Analysis

Date: _____

Home Name: _____

Address _____

Phone: (_____) _____ Fax: (_____) _____

Email: _____

Administrator: _____

Director of Care: _____

Medical Director: _____

Other physicians: _____

1. Number of beds in home _____ Name of resource pharmacist _____

2. Does your home have an admission information package? Yes No
If yes, does it include pain management information? Yes No

3. Is infusion therapy for pain management provided? (subcutaneous, continuous subcutaneous infusion, intervenour, patient controlled analgesia pump, etc.) Yes No
If yes, how is the service provided? Home staff CCAC

4. List policies and procedures for pain management practices currently in place.

5. Are standardized pain assessment tools in place at this time?
For the cognitively intact resident Yes No
For the cognitively impaired resident Yes No

6. When and how often is pain assessed in your home? (Check all appropriate answers)

Admission	<input type="checkbox"/>	Change of condition (e.g., decline in PPS)	<input type="checkbox"/>
Monthly	<input type="checkbox"/>	Change of medication	<input type="checkbox"/>
Quarterly	<input type="checkbox"/>	Annually	<input type="checkbox"/>
No standard at this time	<input type="checkbox"/>		

Other (please explain)

7. Are you currently using a standardized scale to rate or quantify pain?

Yes No

If yes, what scale are you using? (Check all that apply)

Zero to 5 Behaviour

Zero to 10 Faces

Other _____

8. If you replied yes to # 7, when is the scale used? (Check all that apply)

With administration of all scheduled analgesics

After administration of a scheduled analgesic

With every PRN analgesic

Other (please explain) _____

9. Are you currently using a pain monitoring form to collect data related to pain management?

Yes No

10. If you replied yes to # 9, when is the pain monitoring form used? (Check all that apply)

With administration of all scheduled analgesics

After administration of a scheduled analgesic

With every PRN analgesic

Other (please explain) _____

11. Does your home have an interdisciplinary pain management team or pain management resource nurse?

Yes No

Is this team/pain management resource nurse supported by the medical advisor?

Yes No

Is the team/pain champion supported by the management team (i.e. Administrator and Director of Care)?

Yes No

12. Is information on pain management included in the orientation of?

RNs Yes No

RPN's Yes No

HCA/PSW's Yes No

Activation/restorative services Yes No

Volunteers Yes No

13. Is there currently a process in place for measuring the person's/family's satisfaction with pain management?

Yes No

14. Is there currently an audit tool in place for the Continuous Quality Improvement or Quality Assessment Committee to audit pain management?

Yes No

15. How is information on pain management communicated when a person is transferred to another home?

Written narrative comment

Verbal report

Other (please explain):

16. What do you identify as the most important barriers to effective pain management in your care setting?

Please circle the number from 0 to 10 with 10 reflecting the most challenging for each item.

- a. Person's reluctance to report pain (1-2-3-4-5-6-7-8-9-10)
- b. Person's reluctance to take medication (1-2-3-4-5-6-7-8-9-10)
- c. Physician reluctance to treat pain (1-2-3-4-5-6-7-8-9-10)
- d. Nurse reluctance to treat pain (1-2-3-4-5-6-7-8-9-10)
- e. Person is not believed (1-2-3-4-5-6-7-8-9-10)
- f. Inadequate pain assessment by physician (1-2-3-4-5-6-7-8-9-10)
- g. Inadequate pain assessment by nursing staff (1-2-3-4-5-6-7-8-9-10)
- h. Impaired ability of people to verbally communicate pain (1-2-3-4-5-6-7-8-9-10)
- i. Nursing home regulatory issues (1-2-3-4-5-6-7-8-9-10)
- j. Cost of analgesic therapy (1-2-3-4-5-6-7-8-9-10)
- k. Lack of policies and guidelines (1-2-3-4-5-6-7-8-9-10)
- l. Other (please explain):

17. Gaps identified, policies needed, other information gathered:

Date: _____

Signature of Administrator: _____

Signature of the Director of Care: _____

Palliative Performance Scale (PPSv2) version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity <i>with</i> Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.
2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.
4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall 'best fit' using all five columns.

1. Ambulation

The items '**mainly sit/lie**,' '**mainly in bed**,' and '**totally bed bound**' are clearly similar. The subtle differences are related to items in the self-care column. For example, 'totally bed bound' at PPS 30% is due to either profound weakness or paralysis such that the patient not only can't get out of bed but is also unable to do any self-care. The difference between 'sit/lie' and 'bed' is proportionate to the amount of time the patient is able to sit up vs need to lie down.

'**Reduced ambulation**' is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

2. Activity & Extent of disease

'**Some**,' '**significant**,' and '**extensive**' disease refer to physical and investigative evidence which shows degrees of progression. For example in breast cancer, a local recurrence would imply 'some' disease, one or two metastases in the lung or bone would imply 'significant' disease, whereas multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be 'extensive' disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, 'some' may mean the shift from HIV to AIDS, 'significant' implies progression in physical decline, new or difficult symptoms and laboratory findings with low counts. 'Extensive' refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

The above extent of disease is also judged in context with the ability to maintain one's work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (eg. trying to walk the halls).

3. Self-Care

'**Occasional assistance**' means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

'**Considerable assistance**' means that regularly every day the patient needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush his or her teeth or wash at least hands and face. Food will often need to be cut into edible sizes but the patient is then able to eat of his or her own accord.

'**Mainly assistance**' is a further extension of 'considerable.' Using the above example, the patient now needs help getting up but also needs assistance washing his face and shaving, but can usually eat with minimal or no help. This may fluctuate according to fatigue during the day.

'**Total care**' means that the patient is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to him or her.

4. Intake

Changes in intake are quite obvious with '**normal intake**' referring to the person's usual eating habits while healthy.

'**Reduced**' means any reduction from that and is highly variable according to the unique individual circumstances.

'**Minimal**' refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

5. Conscious Level

'**Full consciousness**' implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. '**Confusion**' is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies. '**Drowsiness**' implies either fatigue, drug side effects, delirium or closeness to death and is sometimes included in the term stupor. '**Coma**' in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24 hour period.

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The Palliative Performance Scale version 2 (PPSv2) tool is copyright to Victoria Hospice Society and replaces the first PPS published in 1996 [J Pall Care 9(4): 26-32]. It cannot be altered or used in any way other than as intended and described here. Programs may use PPSv2 with appropriate recognition. Available in electronic Word format by email request to judy.martell@caphealth.org

Correspondence should be sent to Medical Director, Victoria Hospice Society, 1900 Fort St, Victoria, BC, V8R 1J8, Canada

Edmonton Symptom Assessment Scale
Numerical Scale

Name: _____

Please circle the number that best describes:

No pain	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
0	1	2	3	4	5	6	7	8	9	10			
Not tired	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
0	1	2	3	4	5	6	7	8	9	10			
Not nauseated	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
0	1	2	3	4	5	6	7	8	9	10			
Not depressed	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
0	1	2	3	4	5	6	7	8	9	10			
Not anxious	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
0	1	2	3	4	5	6	7	8	9	10			
Not drowsy	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
0	1	2	3	4	5	6	7	8	9	10			
Best appetite	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
0	1	2	3	4	5	6	7	8	9	10			
Best feeling of wellbeing	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
0	1	2	3	4	5	6	7	8	9	10			
No shortness of breath	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
0	1	2	3	4	5	6	7	8	9	10			
Best bowel function	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	Worst possible bowel function
0	1	2	3	4	5	6	7	8	9	10			
Other problem	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; padding: 2px 5px;">10</td> </tr> </table>	0	1	2	3	4	5	6	7	8	9	10	
0	1	2	3	4	5	6	7	8	9	10			

Person's Name _____

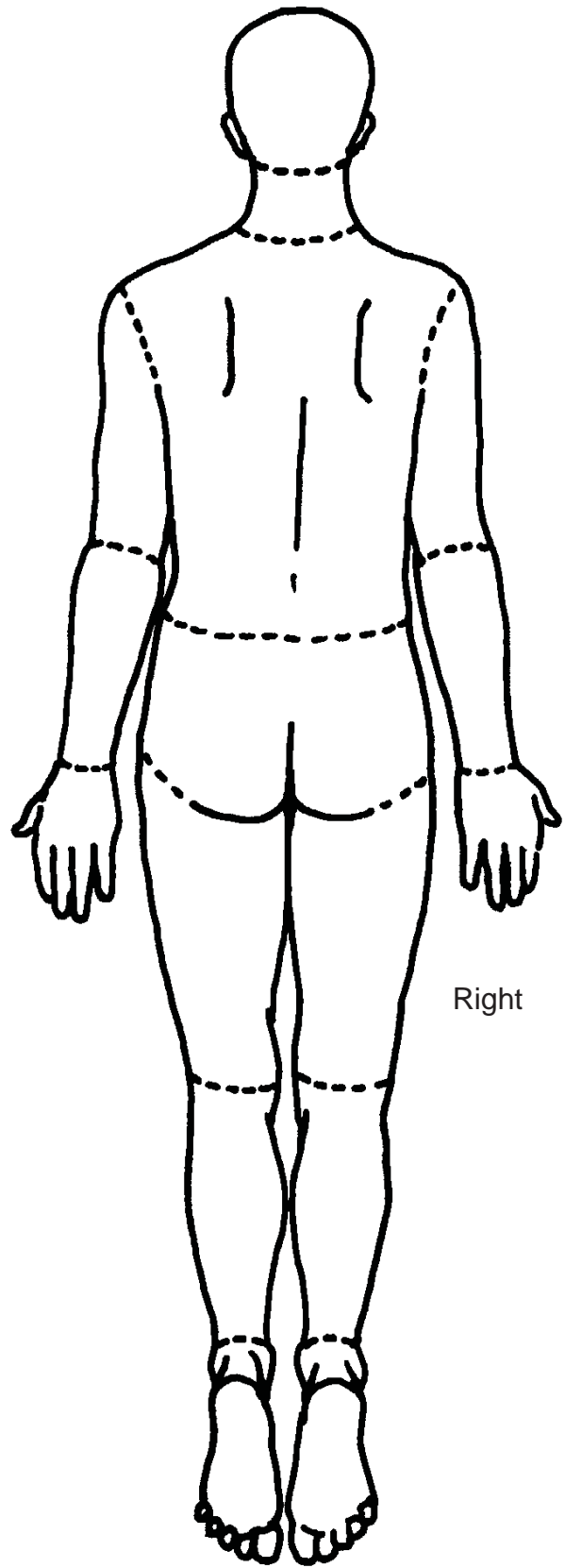
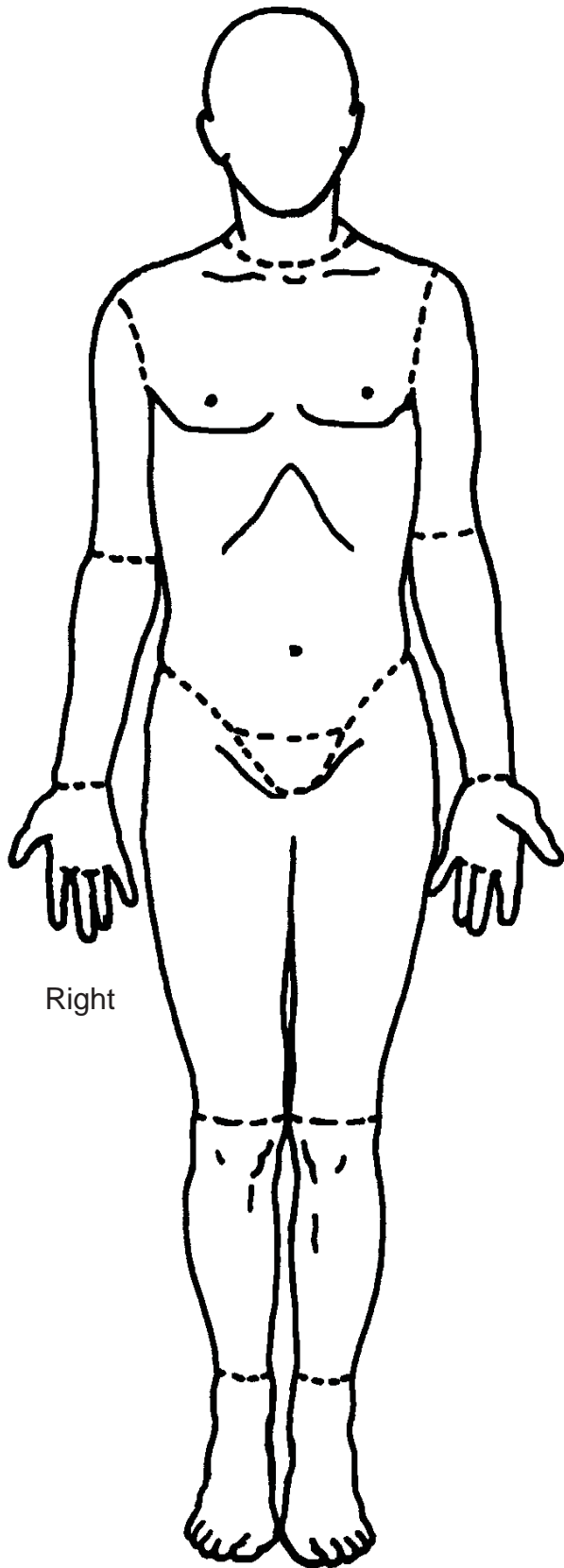
Date _____ Time _____

Complete by (check one)

- Person
- Caregiver
- Caregiver - assisted

BODY DIAGRAM ON REVERSE SIDE

Please mark on these pictures where it is you hurt.



SCREENING FOR THE PRESENCE OF PAIN

INDICATORS for completing a pain assessment if any one of the following occurs:

- The person states pain is present
- There is a change in the person's condition
- The person is diagnosed with a chronic painful disease
- The person has a history of unexpressed chronic pain
- The person has taken pain-related medication within the last 72 hours
- The person exhibits distress-related behaviours (e.g. facial grimace)
- Family, staff, or a volunteer indicate the presence of pain

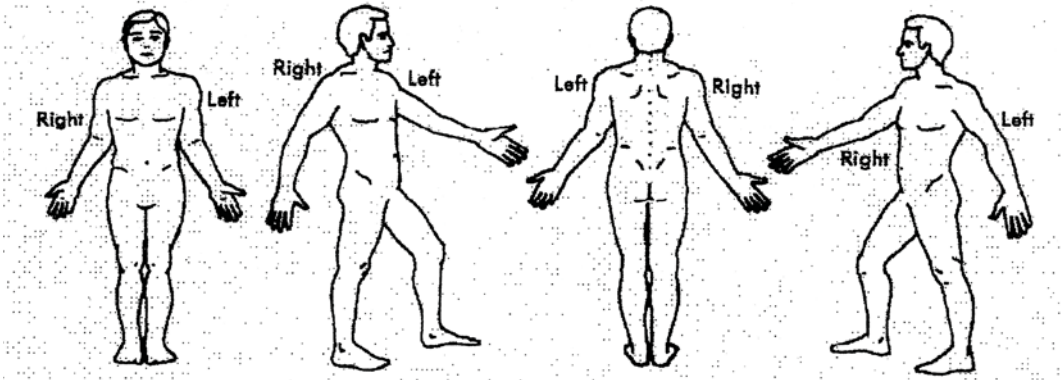
PAIN ASSESSMENT TOOL

Assessment Date (M/D/Y): _____

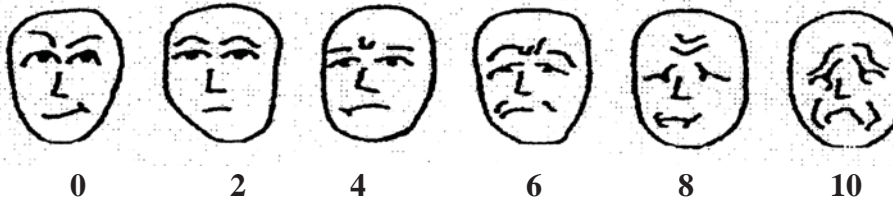
Reason for Assessment:

- New Admission Re-Admission
 Further Assessment Needed

Location Of Pain:



Intensity: Use appropriate pain tool to rate pain subjectively on a scale of 0-10. (Rate pain on a scale of 0-10)



QUESTIONS	COMMENTS
What is the present level of pain?	
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 (come & go)?	
When did the pain start?	
What do you think is the cause of this pain?	
What level of pain are you satisfied with? (if 0 is unattainable)	

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 | <input type="checkbox"/> Other: _____ | | | | |

Effects of Pain On Activities of Daily Living:

- | | | | |
|--------------------------------|------------------------------|-----------------------------|----------------|
| sleep and rest | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| social activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| appetite | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| physical activity and mobility | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| emotions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |
| sexuality/intimacy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Comments-_____ |

Effects of Pain On Your Quality of Life: (happiness, contentment, fulfillment). What would you like to do now that you can't because of the pain or what activity would improve the person's quality of life?

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"/> S.O.B. |
| <input type="checkbox"/> sore mouth | <input type="checkbox"/> weakness | <input type="checkbox"/> drowsy | <input type="checkbox"/> Other: _____ | | | |

Behaviours: What behaviours are present as a result of pain or treatment?

- | | | | | |
|---|---------------------------------------|--|-------------------------------------|---|
| <input type="checkbox"/> calling out | <input type="checkbox"/> restlessness | <input type="checkbox"/> resistant to movement | <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"/> disorientation | <input type="checkbox"/> Other: _____ | | | |

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

Past Medication Used For Pain Management: _____

Support System: _____

Are There Any Other Concerns Related to Pain?

Pain Diagnosis:

- Visceral** – poorly localized, referred, often gradual onset (i.e. liver, pancreas, bowel, bladder)
- Somatic** – well localized, worse with movement (i.e. muscle, bone, joint)
- Incident pain** - breakthrough pain, worse with movement (i.e. severe Osteoarthritis, bone metastases)
- Neuropathic** – burning, deep aching, possibly with numbness and tingling, caused by pressure, invasion or destruction of peripheral or central nervous tissues
- Mixed** – combination of visceral, somatic, and/or neuropathic (i.e. tumor invasion of pancreas, with spread to and destruction of vertebra)
- Unknown** – persistent pain, cause cannot be determined by history and investigations

Care Plan Updated: Yes

Signature: _____

Date: (M/D/Y) _____

5. Please rate your pain by circling the one number that best describes your pain on the **AVERAGE**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine
------------	---	---	---	---	---	---	---	---	---	---	----	--------------------------------------

6. Please rate your pain by circling the one number that tells how much pain you have **RIGHT NOW**.

No pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as you can imagine
------------	---	---	---	---	---	---	---	---	---	---	----	--------------------------------------

7. What treatments or medications are you currently receiving for your pain:

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows most how much **RELIEF** you have received.

No relief	0	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%	Complete relief
-----------	---	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	-----------------

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

B. Mood:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

C. Walking Ability:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

D. Normal Work (includes both work outside the home and housework)

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

E. Relations with other people:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

F. Sleep:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

G. Enjoyment of Life:

Does not interfere	0	1	2	3	4	5	6	7	8	9	10	Completely interferes
--------------------	---	---	---	---	---	---	---	---	---	---	----	-----------------------

Pain Assessment in Advanced Dementia (PAINAD) Scale

Items*	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
Total**				

*Five-item observational tool (see the description of each item below).

**Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

Breathing

1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative sounding respirations on inspiration or expiration. They may be loud, gurgling, or wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative vocalization

1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or murmuring sounds, wails or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or murmuring sounds, wails or laments much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial expression

1. Smiling is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open.

4. Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.

Body language

1. Relaxed is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. Tense is characterized by a strained, apprehensive or worried appearance. The jaw may be clenched (exclude any contractures).
3. Distressed pacing is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. Fidgeting is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging or rubbing body parts can also be observed.
5. Rigid is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding (exclude any contractures).
6. Fists clenched is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. Knees pulled up is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance (exclude any contractures).
8. Pulling or pushing away is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him or herself free or shoving you away.
9. Striking out is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. No need to console is characterized by a sense of well being. The person appears content.
2. Distracted or reassured by voice or touch is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction with no indication that the person is at all distressed.
3. Unable to console, distract or reassure is characterized by the inability to sooth the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. *J Am Med Dir Assoc*. 2003;4:9-15.

Excerpted from Frampton K. "[Vital Sign #5](#)". *Caring for the Ages* 2004; 5(5):26-35. © 2004 Lippincott Williams & Wilkins. All rights reserved. Reprinted with permission.

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident:

Name and designation of person completing the scale:

Date: **Time:**

Latest pain relief given was.....**at****hrs.**

- | | | | |
|------------|--|-----------|---|
| Q1. | Vocalisation
eg. whimpering, groaning, crying
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i> | Q1 | <input style="width: 50px; height: 30px;" type="text"/> |
| Q2. | Facial expression
eg: looking tense, frowning grimacing, looking frightened
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i> | Q2 | <input style="width: 50px; height: 30px;" type="text"/> |
| Q3. | Change in body language
eg: fidgeting, rocking, guarding part of body, withdrawn
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i> | Q3 | <input style="width: 50px; height: 30px;" type="text"/> |
| Q4. | Behavioural Change
eg: increased confusion, refusing to eat, alteration in usual patterns
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i> | Q4 | <input style="width: 50px; height: 30px;" type="text"/> |
| Q5. | Physiological change
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i> | Q5 | <input style="width: 50px; height: 30px;" type="text"/> |
| Q6. | Physical changes
eg: skin tears, pressure areas, arthritis, contractures, previous injuries.
<i>Absent 0 Mild 1 Moderate 2 Severe 3</i> | Q6 | <input style="width: 50px; height: 30px;" type="text"/> |

Add scores for 1 – 6 and record here ➔ **Total Pain Score**

Now tick the box that matches the Total Pain Score ➔

0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe
-------------------------	----------------------	---------------------------	----------------------

Finally, tick the box which matches the type of pain ➔

Chronic	Acute	Acute on Chronic
----------------	--------------	-------------------------

Dementia Care Australia Pty Ltd
 Website: www.dementiacareaustralia.com

DOLOPLUS-2 SCALE

BEHAVIOURAL PAIN ASSESSMENT IN THE ELDERLY

NAME :

Christian Name :

Unit :

DATES

Behavioural Records

SOMATIC REACTIONS					
1 • Somatic complaints	• no complaints	0	0	0	0
	• complaints expressed upon inquiry only	1	1	1	1
	• occasional involuntary complaints	2	2	2	2
	• continuous involuntary complaints	3	3	3	3
2 • Protective body postures adopted at rest	• no protective body posture	0	0	0	0
	• the patient occasionally avoids certain positions	1	1	1	1
	• protective postures continuously and effectively sought	2	2	2	2
	• protective postures continuously sought, without success	3	3	3	3
3 • Protection of sore areas	• no protective action taken	0	0	0	0
	• protective actions attempted without interfering against any investigation or nursing	1	1	1	1
	• protective actions against any investigation or nursing	2	2	2	2
	• protective actions taken at rest, even when not approached	3	3	3	3
4 • Expression	• usual expression	0	0	0	0
	• expression showing pain when approached	1	1	1	1
	• expression showing pain even without being approached	2	2	2	2
	• permanent and unusually blank look (voiceless, staring, looking blank)	3	3	3	3
5 • Sleep pattern	• normal sleep	0	0	0	0
	• difficult to go to sleep	1	1	1	1
	• frequent waking (restlessness)	2	2	2	2
	• insomnia affecting waking times	3	3	3	3
PSYCHOMOTOR REACTIONS					
6 • washing &/or dressing	• usual abilities unaffected	0	0	0	0
	• usual abilities slightly affected (careful but thorough)	1	1	1	1
	• usual abilities highly impaired, washing &/or dressing is laborious and incomplete	2	2	2	2
	• washing &/or dressing rendered impossible as the patient resists any attempt	3	3	3	3
7 • Mobility	• usual abilities & activities remain unaffected	0	0	0	0
	• usual activities are reduced (the patient avoids certain movements and reduces his/her walking distance)	1	1	1	1
	• usual activities and abilities reduced (even with help, the patient cuts down on his/her movements)	2	2	2	2
	• any movement is impossible, the patient resists all persuasion	3	3	3	3
PSYCHOSOCIAL REACTIONS					
8 • Communication	• unchanged	0	0	0	0
	• heightened (the patient demands attention in an unusual manner)	1	1	1	1
	• lessened (the patient cuts him/herself off)	2	2	2	2
	• absence or refusal of any form of communication	3	3	3	3
9 • Social life	• participates normally in every activity (meals, entertainment, therapy workshop)	0	0	0	0
	• participates in activities when asked to do so only	1	1	1	1
	• sometimes refuses to participate in any activity	2	2	2	2
	• refuses to participate in anything	3	3	3	3
10 • Problems of behaviour	• normal behaviour	0	0	0	0
	• problems of repetitive reactive behaviour	1	1	1	1
	• problems of permanent reactive behaviour	2	2	2	2
	• permanent behaviour problems (without any external stimulus)	3	3	3	3
COPYRIGHT		SCORE			

DOLOPLUS-2 SCALE : LEXICON

Somatic complaints

The patients expresses pain by word, gesture, cries, tears or moans.

Protective body postures adopted at rest

Unusual body positions intended to avoid or relieve pain.

Protection of sore areas

The patient protects one or several areas of his/her body by a defensive attitude or gestures.

Expression

The facial expression appears to express pain (grimaces, drawn, atonic) as does the gaze (fixed gaze, empty gaze, absent, tears).

Investigation

Any investigation whatsoever (approach of a caregiver, mobilization, care procedure, etc.).

Washing/dressing

Pain assessment during washing and/or dressing, alone or with assistance.

Mobility

Evaluation of pain in movement: change of position, transfer, walking alone or with assistance.

Communication

Verbal or non-verbal.

Social life

Meals, events, activities, therapeutic workshops, visits, etc.

Problems of behaviour

Aggressiveness, agitation, confusion, indifference, lapsing, regression, asking for euthanasia, etc.

DOLOPLUS-2 SCALE : INSTRUCTIONS FOR USE

1 • Scale use requires learning

As is the case with any new instrument, it is judicious to test it before circulating it. Scale scoring time decreases with experience (at most a few minutes). Where possible, it is of value to appoint a reference person in a given care structure.

2 • Pluridisciplinary team scoring

Irrespective of the health-care, social-care or home structure, scoring by several caregivers is preferable (physician, nurse, nursing assistant, etc.). At home, the family and other persons can contribute using a liaison notebook, telephone or even a bedside meeting. The scale should be included in the 'care' or 'liaison notebook' file.

3 • Do not score if the item is inappropriate

It is not necessary to have a response for all the items on the scale, particularly given an unknown patient on whom one does not yet have all the data, particularly at psychosocial level. Similarly, in the event of coma, scoring will be mainly based on the somatic items.

4 • Compile score kinetics

Re-assessment should be twice daily until the pain is sedated, then at longer intervals, depending on the situation. Compile score kinetics and show the kinetics on the care chart (like temperature or blood pressure). The scale will thus become an essential argument in the management of the symptom and in treatment initiation.

5 • Do not compare scores on different patients

Pain is a subjective and personal sensation and emotion. It is therefore of no value to compare scores between patients. Only the time course of the scores in a given patient is of interest.

6 • If in doubt, do not hesitate to conduct a test treatment with an appropriate analgesic

It is now accepted that a score greater than or equal to 5/30 is a sign of pain. However, for borderline scores, the patient should be given the benefit of the doubt. If the patient's behavior changes following analgesic administration, pain is indeed involved.

7 • The scale scores pain and not depression, dependence or cognitive functions

Numerous instruments are available for each situation. It is of primary importance to understand that the scale is used to detect changes in behavior related to potential pain.

Thus, for items 6 and 7, we are not evaluating dependence or independence but pain.

8 • Do not use the DOLOPLUS 2 scale systematically

When the elderly patient is communicative and cooperative, it is logical to use the self-assessment instruments. When pain is patent, it is more urgent to relieve it than to assess it ... However, if there is the slightest doubt, hetero-assessment will avoid underestimation.

Pain Descriptors

NOCICEPTIVE PAIN

Nociceptive pain starts with the activation and ongoing response of **somatic** or **visceral** pain-sensitive nerve fibres.

Somatic Pain results from activation of pain sensitive structures or nociceptors in the cutaneous and deep musculoskeletal tissues. Somatic pain is typically well localized and may be felt in superficial cutaneous or deeper musculoskeletal structures.

Examples of somatic pain include:

- post surgical incision pain
- skin ulceration
- bone fractures
- bone metastases
- osteo-arthritis
- pain that accompanies myofascial or musculoskeletal inflammation or spasm

Somatic pain is typically felt as aching, gnawing or pressure, and is usually well localized. It may worsen with movement or weight bearing if in the pelvis, hips, femur, joints or spine are involved.

Medical management of somatic pain includes use of opioids, NSAIDs such as ibuprofen or naproxen, corticosteroids such as dexamethasone, calcitonin and bisphosphonates (Pamidronate, Clodronate) for pain due to bone metastasis or pathological fractures. Radiation and chemotherapy may also be used as palliative treatments to manage pain.

Visceral Pain results from infiltration, compression, distension or stretching of thoracic or abdominal viscera. It is poorly localized and is often described as deep, squeezing or pressure and may be associated with nausea, vomiting, and diaphoresis, especially when acute. Visceral pain can be referred to a cutaneous site remote from the site of the lesion (i.e. shoulder pain associated with diaphragmatic irritation) (Coyle & Layman-Goldstein in Matzo & Witt-Sherman, 2001).

Examples of visceral pain include:

- solid viscera e.g. liver, pancreatic pain can be intensely sharp, penetrating
- hollow viscera e.g. bowel, bladder pain is described as a diffuse, colicky pain often accompanied by a feeling of pressure or fullness

Medical management of visceral pain includes use of opioids, NSAIDs and corticosteroids.

NEUROPATHIC PAIN

Neuropathic pain results from injury to the peripheral or central nervous system. In cancer, it commonly occurs as a consequence of tumour compressing or infiltrating peripheral nerves, nerve roots or the spinal cord. It can be a result of surgical trauma, chemotherapy or radiation induced injury to peripheral nerves or the spinal cord.

Examples of neuropathic pain include (Coyle & Layman-Goldstein in Matzo & Witt-Sherman, 2001):

- brachial or lumbosacral plexopathies
- epidural or spinal cord compression
- cauda-equina compression
- post herpetic neuralgia and other neuropathies

Neuropathic pain is sustained by processes in the peripheral nervous system, the central nervous system or both. Pain may be related to:

- the efferent function of the sympathetic nervous system (a complex, rare, and often untreatable syndrome)
- identifiable peripheral pathology (e.g., nerve compression, neuroma formation)
- CNS pathology (e.g., stroke, spinal cord compression or injury, post amputation phantom limb pain, diabetic neuropathy, and post herpetic neuralgia) resulting in deafferentation pain.

Neuropathic pain is described as:

- constant dull ache, sometimes with pressure or vice-like quality accompanied by episodic paroxysms of burning and or sharp, lancinating, shock-like sensations deep aching
- dysaesthesias (burning or spontaneous pain)
- lancinating
- sharp, shooting like an electric shock
- hyperaesthesia, allodynia (unusual sensitivity/pain caused by light touch)
- pins and needles or numbness
- numbness or tingling
- strange descriptors (feet feel wet)

Neuropathic pain is often severe, very distressing, and is sometimes difficult to manage. In addition to opioids and NSAIDs, medical management of neuropathic pain includes the use of tricyclic antidepressants (e.g. amitriptyline, desipramine), anticonvulsants (e.g., carbamazepine, valproic acid, gabapentin), corticosteroids, and local anaesthetics. Palliative radiation and chemotherapy may also prove beneficial.

MIXED PAIN

People may have more than one type of pain. The term mixed pain suggests that some pain syndromes have a multi-factorial pathophysiology. For example, most cancer pain syndromes have a prominent nociceptive component but may also include neuropathic pain due to nerve damage caused by the tumour or the treatment as well as an element of suffering related to loss of function and fear of disease progression.

FICA ~ A Spiritual Assessment Tool

F Faith or Beliefs

Specific questions to elicit responses:

- Do you consider yourself spiritual or religious? Both? Neither?
- What things do you believe in that give meaning to your life?
- What is your faith or belief?

I Importance and Influence of Beliefs

Specific questions to elicit responses:

- Is your faith or belief important in your life?
- What influence does your faith or belief have on how you take care of yourself?
- How have your beliefs influenced your behavior during this illness?
- What role do your beliefs play in regaining your health?

C Community

Specific questions to elicit responses:

- Are you part of a spiritual or religious community?
- Does the community provide support for you? How?
- Is there a person or group of people you really love or who are really important to you?

A Address Care Issues

Specific questions to elicit responses:

- How would you like me, as your healthcare provider, to address these issues while caring for you?

¹ Puchalski, CM. Spiritual Assessment Tool. *Innovations in End of Life Care*. 1999; 1(6): 1-2

The Geriatric Depression Scale (GDS)

*By: Lenore Kurlowicz, PhD, RN, CS, FAAN, University of Pennsylvania School of Nursing and
Sherry A. Greenberg, MSN, APRN, BC, GNP, Hartford Institute for Geriatric Nursing, NYU College of Nursing*

WHY: Depression is common in late life, affecting nearly 5 million of the 31 million Americans aged 65 and older. Both major and minor depression are reported in 13% of community dwelling older adults, 24% of older medical outpatients, 30% of older acute care patients, and 43% of nursing home dwelling older adults (Blazer, 2002a). Contrary to popular belief, depression is not a natural part of aging. Depression is often reversible with prompt and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive and social impairment, as well as delayed recovery from medical illness and surgery, increased health care utilization, and suicide.

BEST TOOL: While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage, et al., has been tested and used extensively with the older population. The GDS Long Form is a brief, 30-item questionnaire in which participants are asked to respond by answering yes or no in reference to how they felt over the past week. A Short Form GDS consisting of 15 questions was developed in 1986. Questions from the Long Form GDS which had the highest correlation with depressive symptoms in validation studies were selected for the short version. Of the 15 items, 10 indicated the presence of depression when answered positively, while the rest (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression.

The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and/or feel easily fatigued. It takes about 5 to 7 minutes to complete.

TARGET POPULATION: The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

VALIDITY AND RELIABILITY: The GDS was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation ($r = .84, p < .001$) (Sheikh & Yesavage, 1986).

STRENGTHS AND LIMITATIONS: The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.

FOLLOW-UP: The presence of depression warrants prompt intervention and treatment. The GDS may be used to monitor depression over time in all clinical settings. Any positive score above 5 on the GDS Short Form should prompt an in-depth psychological assessment and evaluation for suicidality.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGerIRN.org.

The Stanford/VA/NIA Aging Clinical Resource Center (ACRC) website. Retrieved Jan 9, 2007, from <http://www.stanford.edu/~yesavage/ACRC.html>.

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Koenig, H.G., Meador, K.G., Cohen, J.J., & Blazer, D.G. (1988). Self-rated depression scales and screening for major depression in the older hospitalized patient with medical illness. *JAGS, 36, 699-706*.

Kurlowicz, L.H., & NICHE Faculty. (1997). Nursing stand or practice protocol: Depression in elderly patients. *Geriatric Nursing, 18*(5), 192-199.

NIH Consensus Development Panel. (1992). Diagnosis and treatment of depression in late life. *JAMA, 268, 1018-1024*.

Sheikh, J.I., & Yesavage, J.A. (1986). Geriatric Depression Scale (GDS). Recent evidence and development of a shorter version. In T.L. Brink (Ed.), *Clinical Gerontology: A Guide to Assessment and Intervention* (pp. 165-173). NY: The Haworth Press, Inc.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M.B., & Leirer, V.O. (1983). Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research, 17, 37-49*.

Geriatric Depression Scale: Short Form

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Answers in **bold** indicate depression. Score 1 point for each bolded answer.

A score > 5 points is suggestive of depression.

A score \geq 10 points is almost always indicative of depression.

A score > 5 points should warrant a follow-up comprehensive assessment.

Source: <http://www.stanford.edu/~yesavage/GDS.html>



A SERIES PROVIDED BY

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FAST SCALE ADMINISTRATION

The FAST scale is a functional scale designed to evaluate patients at the more moderate-severe stages of dementia when the MMSE no longer can reflect changes in a meaningful clinical way. In the early stages the patient may be able to participate in the FAST administration but usually the information should be collected from a caregiver or, in the case of nursing home care, the nursing home staff.

The FAST scale has seven stages:

- 1 which is normal adult**
- 2 which is normal older adult**
- 3 which is early dementia**
- 4 which is mild dementia**
- 5 which is moderate dementia**
- 6 which is moderately severe dementia**
- 7 which is severe dementia**

FAST Functional Milestones.

FAST stage 1 is the normal adult with no cognitive decline. FAST stage 2 is the normal older adult with very mild memory loss. Stage 3 is early dementia. Here memory loss becomes apparent to co-workers and family. The patient may be unable to remember names of persons just introduced to them. Stage 4 is mild dementia. Persons in this stage may have difficulty with finances, counting money, and travel to new locations. Memory loss increases. The person's knowledge of current and recent events decreases. Stage 5 is moderate dementia. In this stage, the person needs more help to survive. They do not need assistance with toileting or eating, but do need help choosing clothing. The person displays increased difficulty with serial subtraction. The patient may not know the date and year or where they live. However, they do know who they are and the names of their family and friends. Stage 6 is moderately severe dementia. The person may begin to forget the names of family members or friends. The person requires more assistance with activities of daily living, such as bathing, toileting, and eating. Patients in this stage may develop delusions, hallucinations, or obsessions. Patients show increased anxiety and may become violent. The person in this stage begins to sleep during the day and stay awake at night. Stage 6 is severe dementia. In this stage, all speech is lost. Patients lose urinary and bowel control. They lose the ability to walk. Most become bedridden and die of sepsis or pneumonia.

Functional Assessment Staging of Alzheimer's Disease. (FAST)©

STAGE	SKILL LEVEL
1.	No difficulties, either subjectively or objectively.
2.	Complains of forgetting location of objects. Subjective word finding difficulties.
3.	Decreased job function evident to co-workers;
	difficulty in traveling to new locations. Decreased organizational capacity.*
4.	Decreased ability to perform complex tasks (e.g., planning dinner for guests),
	handling personal finances (forgetting to pay bills), difficulty marketing, etc.
5.	Requires assistance in choosing proper clothing to wear for day, season,
	occasion.
6a.	Difficulty putting clothing on properly without assistance.
b.	Unable to bathe properly; e.g., difficulty adjusting bath water temperature)
	occasionally or more frequently over the past weeks.*
c.	Inability to handle mechanics of toileting (e.g., forgets to flush the toilet,
	does not wipe properly or properly dispose of toilet tissue) occasionally or
	more frequently over the past weeks.*
d.	Urinary incontinence, occasional or more frequent.
e.	Fecal Incontinence, (occasional or more frequently over the past week).
7a.	Ability to speak limited to approximately a half dozen different words or fewer,
	in the course of an average day or in the course of an intensive interview.
b.	Speech ability limited to the use of a single intelligible word in an average day
	or in the course of an interview (the person may repeat the word over and over.
c.	Ambulatory ability lost (cannot walk without personal assistance).
d.	Ability to sit up without assistance lost (e.g., the individual
	will fall over if there are no lateral rests [arms] on the chair).
e.	Loss of the ability to smile.

SBAR Report to Physician

BEFORE CALLING THE PHYSICIAN

1. Assess the patient
2. Review the chart for the appropriate physician to call
3. Know the admitting diagnosis
4. Read the most recent Progress Notes and the assessment from the nurse of the prior shift.
5. Have available when speaking with the physician:

Chart, Allergies, Meds, Labs / Results



S

SITUATION

State your **name and unit**

I am calling about: **(Patient Name & Facility)**

The **problem** I am calling about is:

B

BACKGROUND

State the pertinent **medical history/ any recent trauma**

A Brief Synopsis of the **treatment to date and effectiveness**

A

ASSESSMENT

Onset	
Precipitating & Alleviating factors	
Quality	
Region & radiation	
Severity	
Timing	
U "How is the pain affecting the patient?"	

Any changes from prior assessments:

R

RECOMMENDATION

Do you think we should: (State what you would like to see done)

- Order an analgesic? (NB: match the severity of the pain with the analgesic order)
- Come to see the patient at this time ?
- Consult the Pain & Symptom Management Team?
- Order **diagnostic tests?**
- Other _____

Are any tests needed ?

- Do you need any tests? XRAY

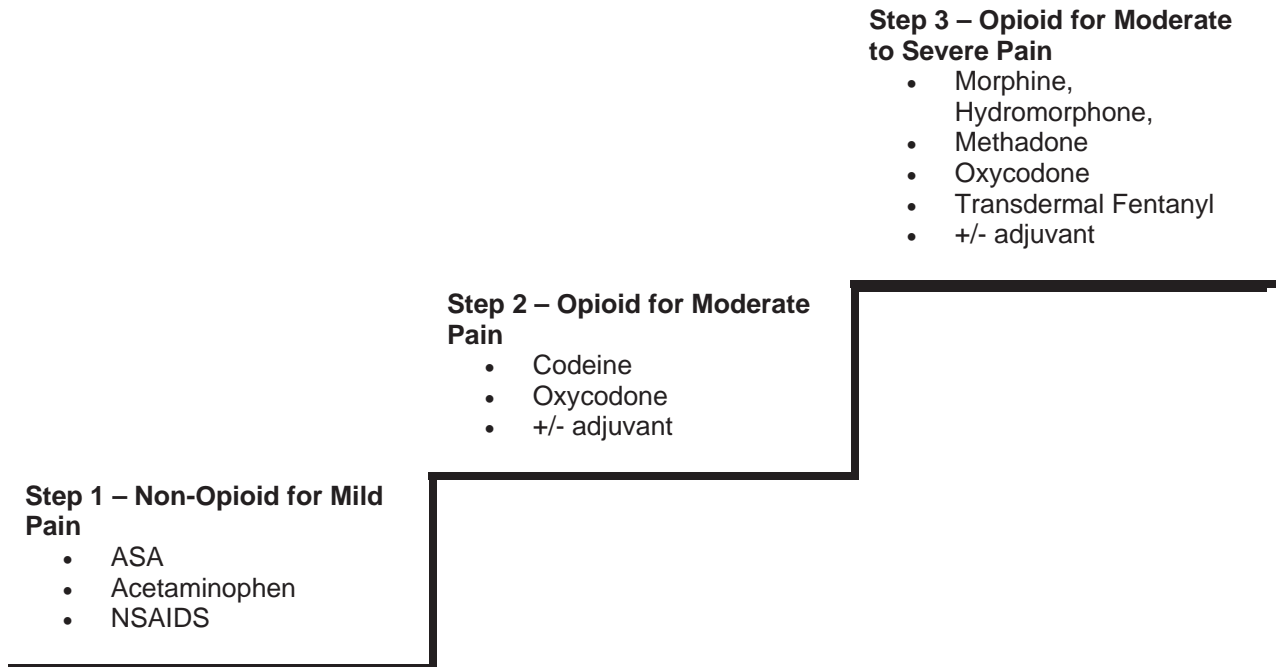
If a change in treatment is ordered, then ask:

- If there the patient does not improve, **when would you want us to call again?**
- Consult the Pain & Symptom Management Team?



Steps in Pain Management:

The WHO (World Health Organization) Ladder (Adapted from WHO Guidelines Handbook on Relief of Cancer Pain, Geneva 1996) is a guideline that may be used to help choose an appropriate analgesic.



Equianalgesic Dosing Chart

All equivalencies are approximate; use this chart as a guideline only.

Oral Routes:

	Ratio
Morphine 10 mg = Percocet 1 tab (5/325) = Oxycodone 5 mg	2:1
Morphine 10 mg = Codeine 100 mg = 3 Tylenol #3 tabs (90/900)	1:10
Morphine 10 mg = Hydromorphone 2 mg	5:1

Oral to Subcutaneous Routes: Ratio 2 (po): 1 (sc)

Morphine 10 mg po	= Morphine 5 mg sc
Hydromorphone 10 mg po	= Hydromorphone 5 mg sc

Subcutaneous Equianalgesia:

Morphine 10 mg sc	= Hydromorphone 2 mg sc
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Conversion to Transdermal Fentanyl. There are various accepted methods.

1. Morphine 60-134 mg po in 24 hrs = Fentanyl 25 mcg patch q72h (CPS, page 783, table 3, 2007)
Note: this range of morphine is very broad which may result in significant under dosing.
2. Morphine 2 mg po in 24 h = 1 mcg/hour of fentanyl transdermal, rounded to the nearest patch size, e.g. 216 mg of oral morphine per 24 hours is approximately equianalgesic to a 100 mcg/hour fentanyl transdermal patch. (*Breitbart W. An alternative algorithm for dosing transdermal fentanyl for cancer-related pain. Oncology 2000; 14:695-702*)
Note: This dose may be excessive when used in a medically compromised patient and/or the frail elderly; use clinical judgment

Guidelines for Calculating Breakthrough Doses (BTD)

Calculate approximately 10 % of the total daily dose of the scheduled opioid and administer it as needed for uncontrolled pain.

The breakthrough dose is calculated in the same way no matter what route of administration is being used (*Managing Cancer Pain The Canadian Healthcare Professional's Reference 2005, Chapter 5 page 35*)

For opioids taken by mouth:

e.g. Morphine 15 mg q12h po = 30mg po total in 24 hours
10 % of 30 mg = 3 mg (max. dose) po **q1h prn** for breakthrough pain

For opioids taken sc:

e.g. Morphine 10 mg q4h sc = 60 mg sc in 24 h
10% of 60 mg = 6 mg (max. dose) sc **q1h prn**

For CSCI:

e.g. Morphine 2.5mg q1h sc continuous infusion = 60mg in 24 hours
10% of 60mg = 6 mg (max. dose) sc **q1h prn* or 3mg q1/2h prn**

**Clinical judgment may indicate the need to lower the calculated dose.*

OPIOID ANALGESICS USED FREQUENTLY IN PALLIATIVE CARE – Page 1 of 2

Drug Name, Dosage Form	BRAND NAME	AVAILABLE STRENGTHS	Quantity Per Packet Sleeve	ODB COVERAGE	Limited Use Criteria (If Applicable)
Codeine					
Immediate release oral tablet		15mg, 30mg, 60mg		Yes	
Oral solution		5mg/ml		Yes	
Long acting oral tablet	Codeine Contin	50mg, 100mg, 150mg, 200mg		No	
Codeine combinations					
1)Acetaminophen 300mg, caffeine 15mg, codeine 15mg	Tylenol #2, Lenoltec #2, Novo-Gesic C15, Atasol-15			Yes	
2)Acetaminophen 300mg, caffeine 15mg, codeine 30mg	Tylenol #3, Lenoltec #3, Novo-Gesic C30, Atasol-30			Yes	
3)Acetaminophen 300mg, codeine 30mg	Empracet 30, Emitec 30			Yes	
4)Acetaminophen 300mg, codeine 60mg	Tylenol #4, Lenoltec #4,			Yes	
5)Acetaminophen 160mg & codeine 8mg/5ml elixir	Tylenol elixir with codeine			Yes	
6)ASA 375mg,caffeine citrate 30mg, codeine 15mg	AC&C 15			Yes	
7)ASA 375mg,caffeine citrate 30mg, codeine 30mg	AC&C 30			Yes	
Fentanyl					
Transdermal reservoir patch	Ran-Fentanyl	25mcg/hr, 50mcg/hr, 75mcg/hr, 100mcg/hr	Box of 5	Limited use	
Transdermal matrix patch	Raltio-fentanyl	25 mcg.h, 50 mcg/h, 75 mcg/h, 100 mcg/h		No	
Fentanyl citrate injectable	Fentanyl citrate	50mcg/ml – 2ml, 5ml, 10ml, 20ml	Sleeves of 5	Yes- if in CSCI	
Hydromorphone					
Immediate release oral tablet	Dilaudid	1mg, 2mg, 4mg, 8mg		Yes	
Oral solution		1mg/ml		Yes	
Controlled release capsule	Hydromorph Contin	3mg, 6mg, 12mg, 18 mg, 24mg, 30mg		Yes	
Suppository		3mg	Box of 6	Yes	
Injectable	Dilaudid	2mg/ml		Yes	
	Dilaudid-HP	10mg/ml – 1ml		Yes	
	Dilaudid-HP Plus	20mg/ml – 50ml		Yes	
	Dilaudid-XP	50mg/ml – 50ml		Yes	
Methadone		available in numerous concentrations manufactured in pharmacy		Yes	
Oral solution	Metadon	10mg/ml		No	
	Methadone Tablet				

Drug Name, Dosage Form	BRAND NAME	AVAILABLE STRENGTHS	Quantity Per Packet Sleeve	ODD COVERAGE	Limited Use Criteria (If Applicable)
Morphine					
Immediate release oral tablet	MOS-10, MOS-20, MOS-40, MOS-60	10mg, 20mg, 40mg, 60mg		Yes	
	MS-IR	20mg, 30mg		Yes	
	Slatex	5mg, 10mg, 25mg, 50mg		Yes	
Oral syrup	Morphitec-1, MOS-1, Morphitec-5, MOS-5, Slatex	1mg/ml, 5mg/ml		Yes	
	Morphitec-10, MOS-10, Slatex	10mg/ml		Yes	
	Morphitec-20, MOS-20, Slatex	20mg/ml		Yes	
	MOS 50	50mg/ml		Yes	
Controlled release tablet	MS Contin	15mg, 30mg, 60mg, 100mg, 200mg		Yes	
		10mg, 15mg, 30mg, 60mg, 100mg, 200mg		Yes	
Controlled release capsule	M-Eslon				
	Kadian	20mg, 50mg, 100mg		Yes	
Suppository	MS-IR	10mg, 20mg, 30mg	Boxes of 24	Yes	
Sustained release suppository	MS Contin	30mg, 60mg, 100mg, 200mg	Cartons of 24	Yes	
		1mg/ml – 10ml, 50ml; 2mg/ml – 1ml, 50ml; 5mg/ml – 30ml;		No	
Injectable	Morphine Sulfate Injection USP	10mg/ml – 1ml		No	
		15mg/ml – 1ml		Yes	
		15mg/ml – 30ml multidose vial		No	
	Morphine HP	25mg/ml – 1ml, 4ml		No	
	Morphine HP-50	50mg/ml – 1ml		Yes	
		50mg/ml – 5ml, 10ml, 50ml		No	
Oxycodone					
Immediate release oral tablet	Supraol	5mg, 10mg		No	
Long acting oral tablet	Oxycontin	10mg, 20mg, 40mg, 80mg		Limited Use	201-tx of chronic pain in pt who can't tolerate/failed tx with listed long acting opioid
Suppositories	Supraol	10mg, 20mg	Box of 12	No	
Oxycodone Combinations					
Acetaminophen 325mg & Oxycodone 5mg	Oxycocet, Endocet			Yes	
ASA 325mg & Oxycodone 5mg	Oxycodan, Endodan			Yes	
Tramadol	Tramacet	37.5 mg tramadol 325 mg acetaminophen		No	No
	Zytram XL (OD)	150mg, 200mg, 300mg, 400mg (taken once daily)		No	No

Used with permission from Erie St.Clair Palliative Care Tools Manual (2007)

Fentanyl Patch Linked to Another Death in Canada

Incidents associated with fentanyl patches have previously been described by both the Institute for Safe Medication Practices Canada (ISMP Canada) and its US counterpart (ISMP). In August 2006, ISMP Canada highlighted the deaths of two Canadian adolescents, reviewed the voluntary reports that had been received to date, and made recommendations for preventing similar incidents.¹ ISMP (US) recently reported that fentanyl patches continue to be inappropriately prescribed, dispensed, and administered to opioid-naïve patients with acute pain.² Advisories and warnings about the use of fentanyl patches have been issued by Health Canada^{3,4,5} the US Food and Drug Administration,⁶ and manufacturers⁷. In addition, according to a recent news report, the Office of the Chief Coroner for Ontario is reviewing several deaths involving fentanyl patches.⁸ Use of transdermal fentanyl can be an effective option for the treatment of chronic pain; however, its use also continues to pose problems for health care providers and their patients.

The following case was recently reported to ISMP Canada and is shared to provide an additional alert:

An adult patient with a history of chronic obstructive pulmonary disease (COPD) presented to an emergency department for management of severe back and leg pain. The patient had been receiving acetaminophen with codeine on an as-needed basis (to a maximum of 480 mg codeine per day) and had received a prescription for oral hydromorphone 2-4 mg every four hours as needed the day before from the family physician. In the emergency department, the patient was treated with intravenous ketorolac with effect, and a fentanyl patch was applied. The patient was also instructed to continue taking the previously prescribed pain medications as needed. Three days later, the patient was experiencing severe pain and returned to the family physician, who increased the fentanyl patch dose from 75 mcg/hour to 125 mcg/hour. The prescription for the new patch also included instructions for the patient to continue taking the oral hydromorphone as needed for pain. The patient returned to see the family physician the next day, reporting that the pain had improved. That evening, the patient appeared confused. The following morning, the patient was found unresponsive. Although emergency services were called, resuscitation measures were unsuccessful and the patient died.

ISMP Canada did not receive all the necessary information required for an in-depth root cause analysis⁹ but the following factors were identified as *possibly* contributing to this sentinel event:

- significant increase of opioid dose within a short time frame;
- complexity of titrating fentanyl patch doses;
- lack of awareness on the part of the patient and family members about the potential side effects of opioid use that would require immediate medical attention; and
- the presence of underlying COPD.

Recommendations

In addition to the recommendations made in a previous bulletin on this topic,¹ the following measures are recommended to reduce the risk of medication incidents associated with fentanyl patch therapy.

1. Prescribing and Administration of Fentanyl Patches

- Ensure that the complete medical history and full medication history are available to verify that all criteria for initiating and continuing fentanyl patch therapy are met.
- Consider the value of adjunctive treatment (e.g., a nonsteroidal anti-inflammatory agent) to decrease the opioid dose requirement.
- Ensure the patient is sufficiently opioid-tolerant for the fentanyl patch dose prescribed (e.g., for a 25 mcg/hour fentanyl patch, patients should be receiving the equivalent of at least 60 mg oral morphine per day, and have been taking the opioid around-the-clock for an extended period of time.¹⁰ Refer to the product monograph for additional information).
- Ensure that the patient and family members understand how the product is to be used, are aware of the signs and symptoms of opioid overdose and know to remove the patch and seek immediate medical attention should signs of overdose occur. (The Duragesic[®] monograph identifies a number of key issues to be reviewed with patients and provides a consumer information sheet.¹⁰)
- When possible, ask family members who are with the patient at various times of the day and night if the patient is unknowingly experiencing any dangerous side effects.

2. Dispensing of Fentanyl Patches

- Ensure that each patient's medication profile is reviewed in full by a pharmacist whenever a new prescription or dose change for fentanyl patch therapy is received.
- Consider implementing computerized alerts in pharmacy information systems for scenarios that may require extra attention (e.g., dosage increase of a fentanyl patch that is greater than 25 mcg/hour or a dose increase prescribed in less than 6 days).
- For outpatients, provide and review written information with the patient (and family) whenever a new fentanyl patch dose is dispensed to ensure that information (e.g., signs and symptoms of overdose) is not overlooked.

3. Manufacturers of Fentanyl Patches

- The following considerations for product monographs for the fentanyl patch are recommended:
 - ◆ Include information that will assist practitioners to assess opioid tolerance. Such information is currently lacking in the product monographs for all brands of fentanyl patches.

- ◆ Include in the product monograph a checklist or algorithm for initiation and titration of the fentanyl patch.

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John Senders, PhD, Professor Emeritus, Faculty of Applied Sciences, University of Toronto; and

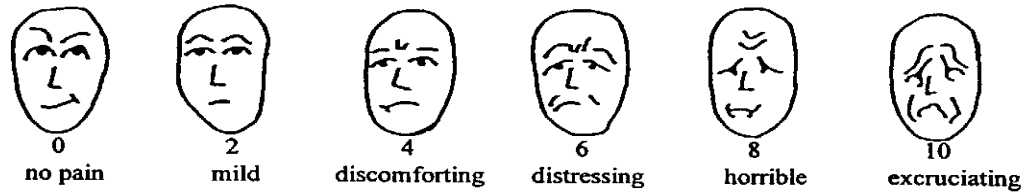
Homer Yang, MD CCFP FRCPC, Professor Chair and Chief Anesthesiology, University of Ottawa and The Ottawa Hospital.

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Facial Grimace & Behaviour Checklist Flow Charts

Name: _____ Active Resting Time: _____



Regular pain Medication: _____ Rescue/PRN medication _____

Month: _____

Date or Time																			
FACIAL SCORE																			
10																			
8																			
6																			
4																			
2																			
0																			
PRN medication																			

Facial Grimace Score The facial grimace scale scores the level of pain (from 0-10 on the left) as indicated by the resident. Assessment is done once daily or more (14 days are indicated above). This assessment of the degree of discomfort should be done at the same time every day and during the same level of activity. **Note if rescue/PRN medication is given; yes (y), no (n) or dose.**

BEHAVIOR CHECKLIST

10 - Always 8 – Mostly 6 - Often 4 – Occasionally 2 – Rarely 0 - Never

Date or Time																			
BEHAVIOUR																			
eats poorly																			
tense																			
quiet																			
indicates pain																			
calls out																			
paces																			
noisy breathing																			
sleeps poorly																			
picks																			
PRN medication																			

Behaviour Checklist Behaviour changes can be used to assess pain or distress, and thereby evaluate the efficacy of interventions. At the top of the scoring graph, when the specific behaviour has been observed, it can be rated from 10 (always) to 0 (never). The behaviours being rated and scored over 24 hours are listed down the left column. This chart scores 9 different behaviours over 14 days. The caregiver can expand on the checklist, i.e., rocking, screams, etc. **Note if rescue/PRN medication given.** Both tools may be adapted for individual use.

GUIDELINES FOR USE OF THE PAIN FLOW RECORD

1. A Pain Flow Record is initiated to ensure that those with identified pain are monitored and that pain is managed.
2. As much as possible, the person should be involved in using the Pain Flow Record.
3. The current Pain Flow Record is kept _____. Completed pages are filed in the _____ of the person's record.
4. Under "REGULAR PAIN MEDICATION" include any medication which would have an effect on the patient's pain, i.e.:
adjuvants for neuropathic pain
5. Showing the person a pain-rating tool with a 0-10 scale, ask, "What number would you give your pain right now?"
Persons who cannot relate to numbers may use the descriptive words on the tool. Staff should assign the appropriate number in recording. Using this question provides continuity for the patient and a more consistent basis for scoring of pain.
6. Complete the pain score using the key at the top of the flow record indicating preadministration pain level.
7. RNAO Best Practice Guidelines recommend reassessment of the pain score within one hour after administration of pain medication to monitor the effectiveness of the medication.
8. Indicate the time of use of the regular medication and/or breakthrough medication.
9. Indicate quality of pain per the key at the top of the flow record
10. Indicate location of pain, at the time of giving the pain medication
11. May discontinue use of this form on a regular basis when pain is stable using the following criteria; that is, for 3 consecutive days of pain rated at less than 4 and using 3 or less BTP doses/per 24 hours.
12. As a result of using this Pain Flow Record, notify the physician when:
 - ❖ More than 4 BTP doses are needed in a 24 hour period depending on the individual circumstances
 - ❖ The person consistently reports pain of $\geq 4/10$ for 24 – 48 hours depending on individual circumstances
 - ❖ The person reports sudden onset of new pain