

A FOCUS ON PAIN MANAGEMENT AND FALLS

WHAT IS PAIN?

Pain is a common complaint as people age. We all perceive pain differently based on our past memories, emotions and personal expectations. Pain is a sensation that hurts – from physical causes or mental anguish. It is estimated that almost 10% of long term care residents live with unresolved pain. CIHI data also notes that 11% of those in long term care experienced worsened pain in the last 3 months (2014-2015 data). Pain management goals should result in an improvement in a person's ability to do things, to give them comfort, and improve their quality of life. Poorly controlled pain can lead to functional impairment, depression, anger, social isolation, low self-esteem, impaired relationships, and poor quality of life.

PAIN ASSESSMENT

Choosing a suitable pain assessment for **initial** and **ongoing** evaluation is essential for optimal pain management. Pain in cognitively impaired residents may present as aggression, irritability or restlessness. Reviewing past medical history, coping skills and standardized assessments are important for deciding if there is a need for additional treatment and monitoring if existing therapies are working. Pain assessment should evaluate pain AND function in residents. Pain scores should be documented in a location that allows all members of the health care team to collaborate together to initiate or change drug and non-drug treatments. While elimination of pain is not realistic in all cases, improvement in pain and function could increase a resident's sense of well-being and overall quality of life.



EXAMPLES OF PAIN ASSESSMENT TOOLS

Cognitively Intact:

- Numeric Rating Scale (NRS) - rate pain on a scale of 0 (no pain) to 10 (worst possible pain)
- Verbal Descriptor Scale (VDS) - chooses words on a thermometer to indicate pain level

Cognitively Impaired:

- Abbey Pain Scale (also evaluates physical changes - skin tears, arthritis)
- Pain Assessment for Seniors with Limited Ability to Communicate (PASCLAC-II)
- Pain Assessment in Advanced Dementia (PAINAD)

These evaluate behaviors (vocalizations, body language) and physiological changes (breathing, flushing) associated with pain.

PAIN MANAGEMENT

Here are some principles of pain management:

- Document baseline pain status and regularly assess changes in pain or behaviour including activity levels.
- Use a combination of drug and non-drug management strategies.

- Use an interdisciplinary approach to pain management. Administer medications on a **regular** schedule with a goal of titrating to lowest effective dose. This is important in cognitively impaired residents who are not able to communicate pain needs.
- Start with lower opioid doses for elderly residents. They are more susceptible to adverse effects. Falls occur more often within the first 7 days of medication dose changes.

NON-PHARMACOLOGICAL APPROACHES TO PAIN MANAGEMENT

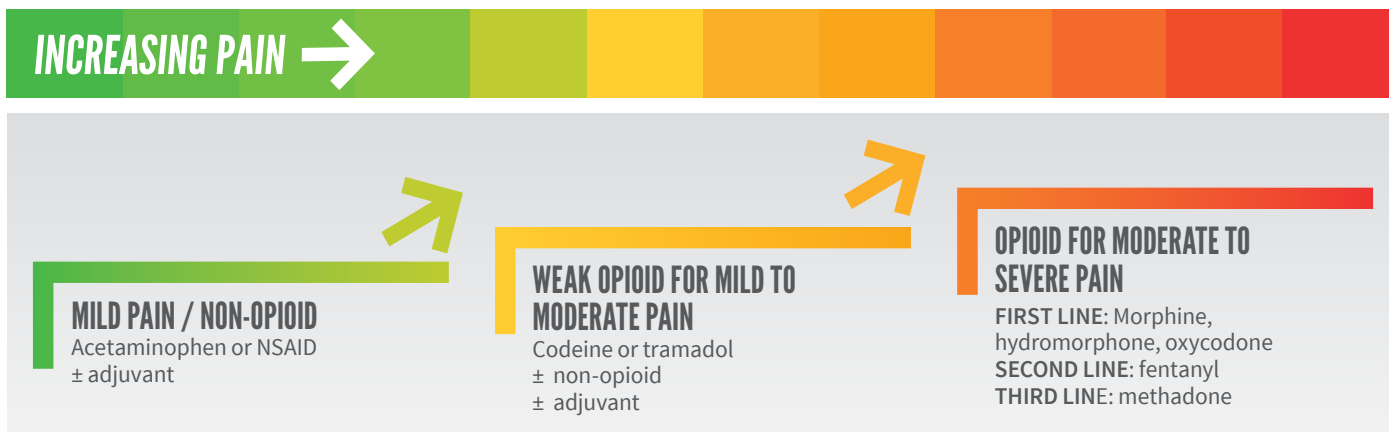
Non-pharmacological interventions can be used alone or in combination with pharmacological therapy for pain management. The benefit of non-pharmacological interventions is enhanced when combined with medications.

These interventions can include the following:

- Physiotherapy or exercise
- Adjust position in bed or chair frequently
- Distraction (deep breathing, music, relaxation)
- Application of heat
- Massage

USING MEDICATION FOR PAIN MANAGEMENT

When initiating analgesia, utilize the stepped approach below. (WHO)



ADVERSE EFFECTS OF OPIOIDS

Elderly residents are more susceptible to adverse effects of opioids due to declining renal function, albumin levels, multiple concomitant medications and disease states. Regularly monitor for over-sedation, cognitive impairment and constipation. Over-sedation may put residents at risk of falls and fractures. Respiratory depression can result from rapid dose increases of opioids or use of other CNS depressants such as benzodiazepines and alcohol. Adverse effects are dose-related so it is important to use non-pharmacological approaches when possible and regularly assess pain and function.

CAN WE SWITCH BETWEEN OPIOIDS?

In some cases it may be beneficial to switch to an alternative opioid if therapy is ineffective or adverse effects occur. For example, constipation is more common with codeine-containing products. To switch, convert the current daily dose to the morphine equivalent. Use this to then calculate the dose of the new opioid. Start the new opioid at 50-75% of the calculated equivalent dose. Add PRN doses for breakthrough pain of up to 10% of the total daily opioid dose. Monitoring should be increased during the switching period to monitor for both pain control and adverse effects.

ORAL AGENT	Equiv. to oral morphine 30 mg	To convert to morphine equivalent, multiply by:
Morphine	30 mg	1
Codeine	200 mg	0.15
Oxycodone	20 mg	1.5
Hydromorphone	6 mg	5
Meperidine	300 mg	0.1
Methadone and tramadol	Conversion not reliably established	

FALLS PREVENTION

Falls are the leading cause of injury-related hospitalization in the elderly. Most factors that lead to falls are preventable. Consider implementing the following to reduce falls:

- **Chronic disease management:** Ensure appropriate treatment of medical conditions (hypotension, pain, etc.).
- **Medication review and modification:** Medication reviews to deprescribe unnecessary medication. Gradual and supervised withdrawal of certain medications can decrease the risk of falls.
- **Environment modification:** Modify existing environmental falls risk and evaluation of daily activities.
- **Exercise programs:** Exercise was shown to be effective for community-dwelling older people. Exercises should target balance, gait and strength training.
- **Nutrition and supplements:** Vitamin D 800-2000iu daily alone or with calcium reduces the risk of falls by 39%.

• Vision referral and correction:

Address all vision concerns; any remediable visual abnormalities should be treated.

• Risk assessment:

Screen for falls risk on admission, quarterly and after any decline in health status. Conduct a multifactorial risk assessment at least once a year. This assessment should include a physical examination, environmental assessment, review of falls history, gait and mobility review, and muscle strength assessment.