Participant Questions

Assessment and Monitoring
Understanding care and monitoring needs to be very individualized and depends upon resident condition. What is the standard or suggested frequency for ongoing monitoring of pain (daily, weekly, etc)?

For routine medications, is pre-assessment and post-assessment necessary? How often do we monitor residents on routine meds?

When should comprehensive pain assessment be done?

The most critical aspect of pain assessment is that it is done on a regular basis (e.g., once a shift, every 2 hours) using a standard format. To meet the individual’s needs, pain should be reassessed after each intervention to evaluate the effect, and to determine whether modification is needed. The time frame for reassessment also should be based on the individual’s condition, the individual’s self-report of pain and the severity and chronicity of pain.

How do we know when it is pain or progressive dementia?
General physical examination will help to rule out treatable conditions. Behavior deterioration in individuals without dementia may be associated with pain, undiagnosed fractures, gastroesophageal reflux, abnormal reaction to medications, head trauma, etc.

Is it encouraged to offer and use holistic pain management during assessments?
For many years, there has been a push to increase the focus on treating the individual as a whole person, not just his or her medical condition—often referred to as “holistic care.” Holistic pain management and assessments are encouraged. Health care providers should work with the individual to resolve pain issues within the context of the whole pain experience, and thus focus on the whole person, identifying the cause of pain, contributing factors, effects of pain and treatment on the individual, etc.
Tools
Are there assessment and reassessment tools for pain severity and chronicity?
Tools mentioned in the presentation have been developed and validated to assess the intensity of the pain. Chronicity of the pain is assessed by obtaining a pain history from both the medical record and the individual. When selecting a Pain Assessment Tool, consider the age, physical, emotional, cognitive status and preference of the individual.

The DS-DAT scale was not mentioned. Is this still a validated pain scale?
Yes. Please see Discomfort Scale for Dementia of the Alzheimer’s Type (DS-DAT) at http://www.greatseminarsandbooks.com/Tips/Entries/DiscomfortScale.htm

Our hospice uses the FLACC scale (Face Legs Activity Cry Consolability). It looks a lot like the PAINAD. Is it similar?

Is the PAINAD assessment tool derived from the FLACC scale and is the FLACC scale appropriate for use with these individuals?

The Pain Assessment in Advanced Dementia Scale, known as the PAINAD Scale, was developed by the E.N. Rogers Memorial VA Hospital in Bedford, Massachusetts, for individuals with advanced dementia.

It was developed specifically for all levels of nursing staff to use since they are closest to the individual and can observe them carefully and often. It was developed so that it would be easily used to measure pain--truly--as the fifth vital sign. The PAINAD Scale is a hybrid tool.

It has features of the FLACC Scale (used for newborns and children) and features of the Discomfort Scale of Dementia of the Alzheimer Type (DSDAT) Scale (developed for advanced Alzheimer patients).”

PAINAD measures facial expressions, body language such as relaxed to rigid, vocalization such as moaning and crying, and consolability.

The Face, Legs, Activity, Cry, Consolability (FLACC) was developed by the University of Michigan Medical Center for post-op pediatric patients in 1997.

The FLACC Scale measures facial expressions; leg movements such as relaxed, restless, kicking; activity such as lying quietly to rigid, jerking; crying and consolability.
Which pain scale is most appropriate for a geriatric patient with severe cognitive deficits the PAINAD or Wong-Baker?

PAINAD

Is the Wong Baker Faces appropriate for Long-Term Care?

Of the existing faces pain scales, the Wong-Baker has had limited testing for use by older adults and conceptually has some issues when used with older adults.

1. The scale uses a happy face and a crying face. This can confuse other feelings (happiness, joy) with no pain/pain.
2. The scale also uses tears which for many adults, especially men, can be an issue in selecting a face that acknowledges pain – especially in those who are stoic and would think tears/crying is not acceptable.
3. Limited publication regarding its use with older adults.

The Faces Pain Scale is recommended for several reasons:

4. The FPS-R has an adult face/expression (without tears) and includes facial action units that are known to occur in humans when experiencing pain (raised brow, open mouth, nasal fold increases and tightened eyes).
5. This scale has been evaluated in Caucasian, African-American and Asian older adults with a number of publications to document validity.

For these reasons, the FPS-R is recommended. For additional information, you may visit www.GeriatricPain.org.

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Other Strategies

Can diversionary tactic be helpful when dealing with pain?

Older adults are at higher risk of having side effects from pharmacological treatment due to age-related physiological changes and increased use of multiple medications for managing multiple chronic health conditions. Therefore, non-pharmacological treatments should be implemented, whenever possible, to accomplish maximum pain relief with the fewest side effects. It is recommended that non-pharmacological pain treatments be used as complementary therapy rather than as a substitute for pharmacological pain treatments.

Evidenced-Based Geriatric Nursing Protocols For Best Practices
Do non-pharmacologic therapies, such as massage and music therapy help alleviate pain in individuals receiving Hospice care?
People naturally use many non-drug strategies, such as distraction, imagery, massage, breathing, meditation, heat and cold, and music to alleviate pain. Before suggesting or instructing people in the use of non-drug techniques, nurses need to be aware of the methods used effectively and preferred by the patient. Massage of the back has been used to improve circulation, promote comfort, and enhance sleep. Hand and foot massage has been used as an alternative to back and body massage. The duration of massage varies from 5 to 20 minutes. Massage has a beneficial effect on anxiety, tension, depression, and stress hormones. The evidence on the beneficial effect of massage in reducing pain is positive, but due to the few studies, a firm conclusion cannot be drawn. It has been documented that soothing or sedating music produces a reduction in pain intensity and short-term reductions in pain, distress or anxiety.

Is aromatherapy appropriate? Does it need to be ordered and approved by a physician?
Aromatherapy, with or without massage, is used as complementary therapy, and is employed in cancer and palliative care to improve quality of life and to reduce psychological distress. Some studies have shown benefits of aromatherapy; however, there is only limited evidence to support its effectiveness. Essential oils have a range of possible adverse effects on individuals, as well as on others in the room, because they are volatile and produce vapors that are inhaled by everyone in the vicinity. Undesired effects such as nausea, rash, headache, respiratory problems, etc. may occur. It is advisable to get aromatherapy approved by a physician.

We are looking to pipe music into certain areas of our nursing facility for clients prior to giving pain medication. How valuable is music therapy to reduce pain?
"A recent meta-analysis of 51 studies examining the effect of music on pain concluded that although music produced a significant reduction in pain intensity (0.5 units), this result may not reflect a clinically important change. Gordon and colleagues suggest a 1.5 to 2.0 unit change in pain intensity on a 0-10 scale constitutes a clinically important difference. Recently published studies, all conducted on patients undergoing cardiovascular procedures, found a significant short-term reduction in pain, distress, or anxiety after exposure to music. In each of these studies, music was used during an episode of increased pain (e.g., getting up from a chair). While these studies hold promise, currently the evidence for the effectiveness of music in reducing acute pain is weak to moderate."

Patient Safety and Quality: An Evidence –Based Hand book for Nurses
Complementary or alternative medicine therapy may include relaxation, exercise, massage, reflexology, prayer, biofeedback, hypnotherapy, shamanism, art, music, dance, acupuncture, meditation, herbalism, and homeopathy. Nurses can learn these kinds of techniques with minimal preparation. Adequate assessment and an individual’s permission are prerequisite for implementation. Some therapies may alter physiological responses, including physician-prescribed therapies. Nurses are taught holistic approaches to nursing; however, a nurse needs to be aware of Nurse Practice acts and practice only within that scope.

**Medication**

**Can you re-state the time frames for routine medication?**

Time frames for routine medications for pain will depend on the medication prescribed, dose and route for that individual.