How to fail at pain management

Pain in the older adult.

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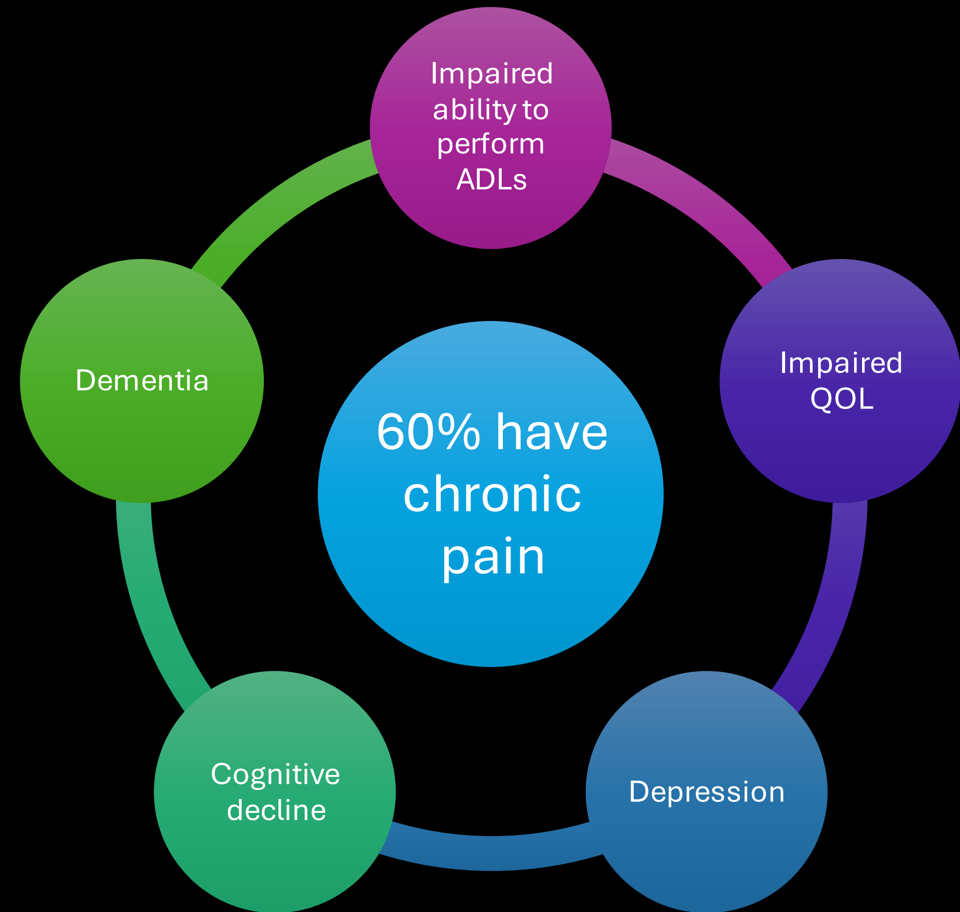
Session aims

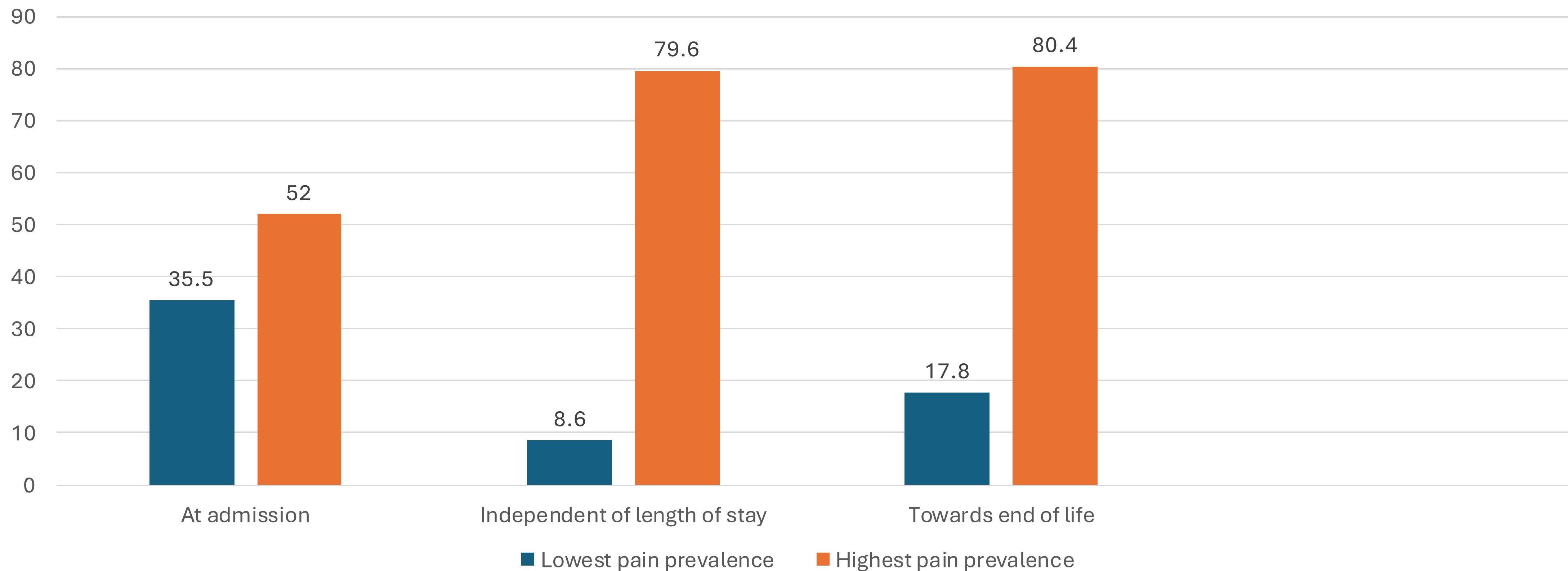
- Identify the main causes and prevalence of pain in older adults with a particular focus on pressure ulcers.
- Describe the impact of pain on the individual in terms of cognition, psychological wellbeing and physical health.
- Describe how to assess pain.
- Select appropriate pharmacological and non-pharmacological management strategies.

1. Assume everyone is okay unless they tell you otherwise

- Prevalence
  - increases with age
  - Is higher in women
- Common pain sites
  - Back, leg, knee, hip, other joints

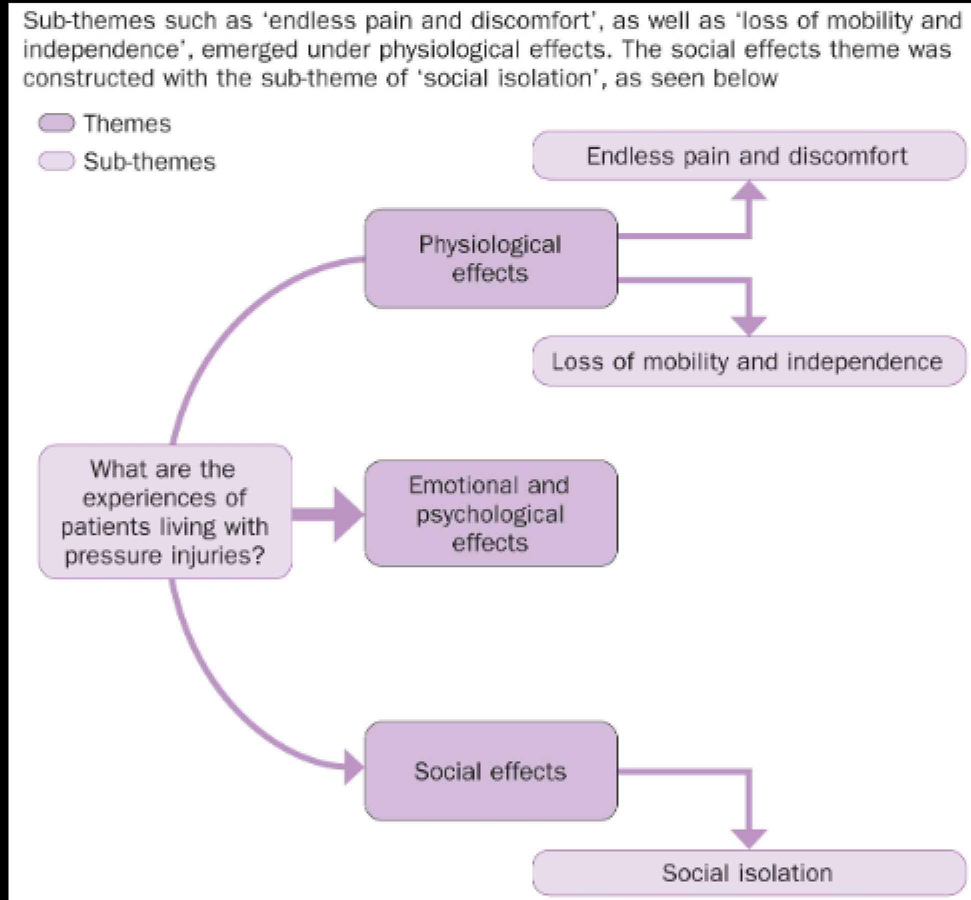


2. Assume that people with dementia don’t suffer because of pain.



Helvik et al 2023

3. Underestimate the consequences of pressure ulcers.



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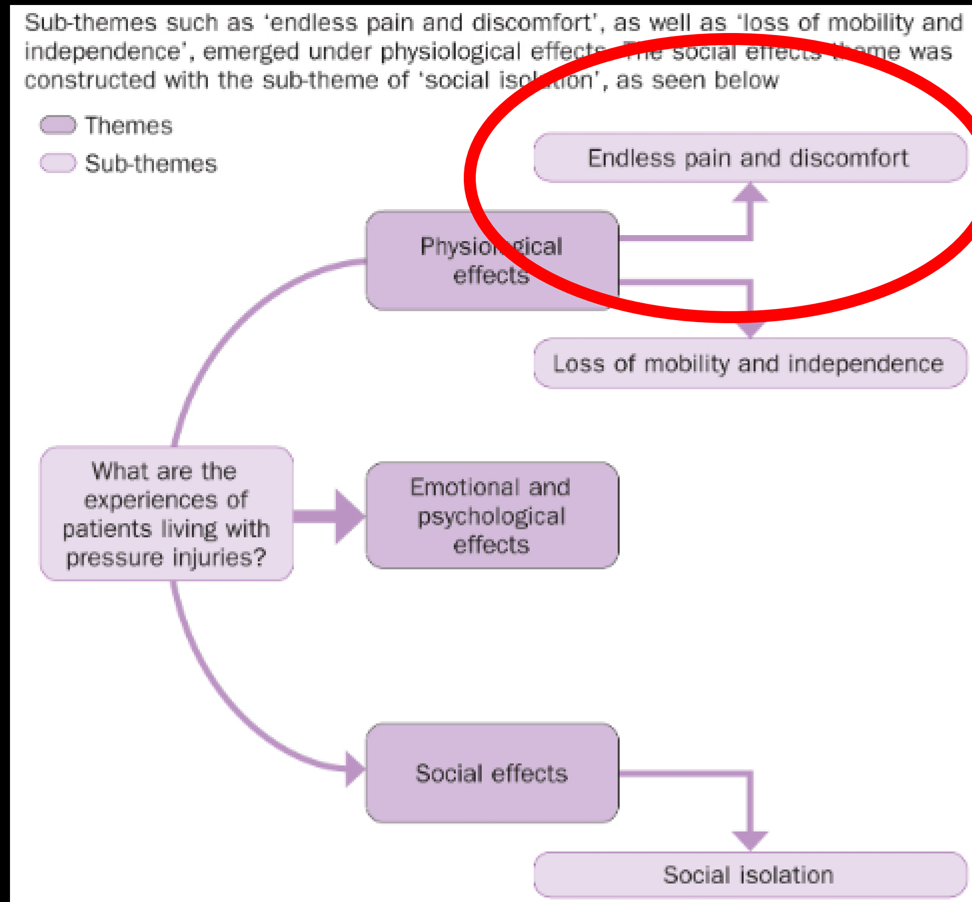
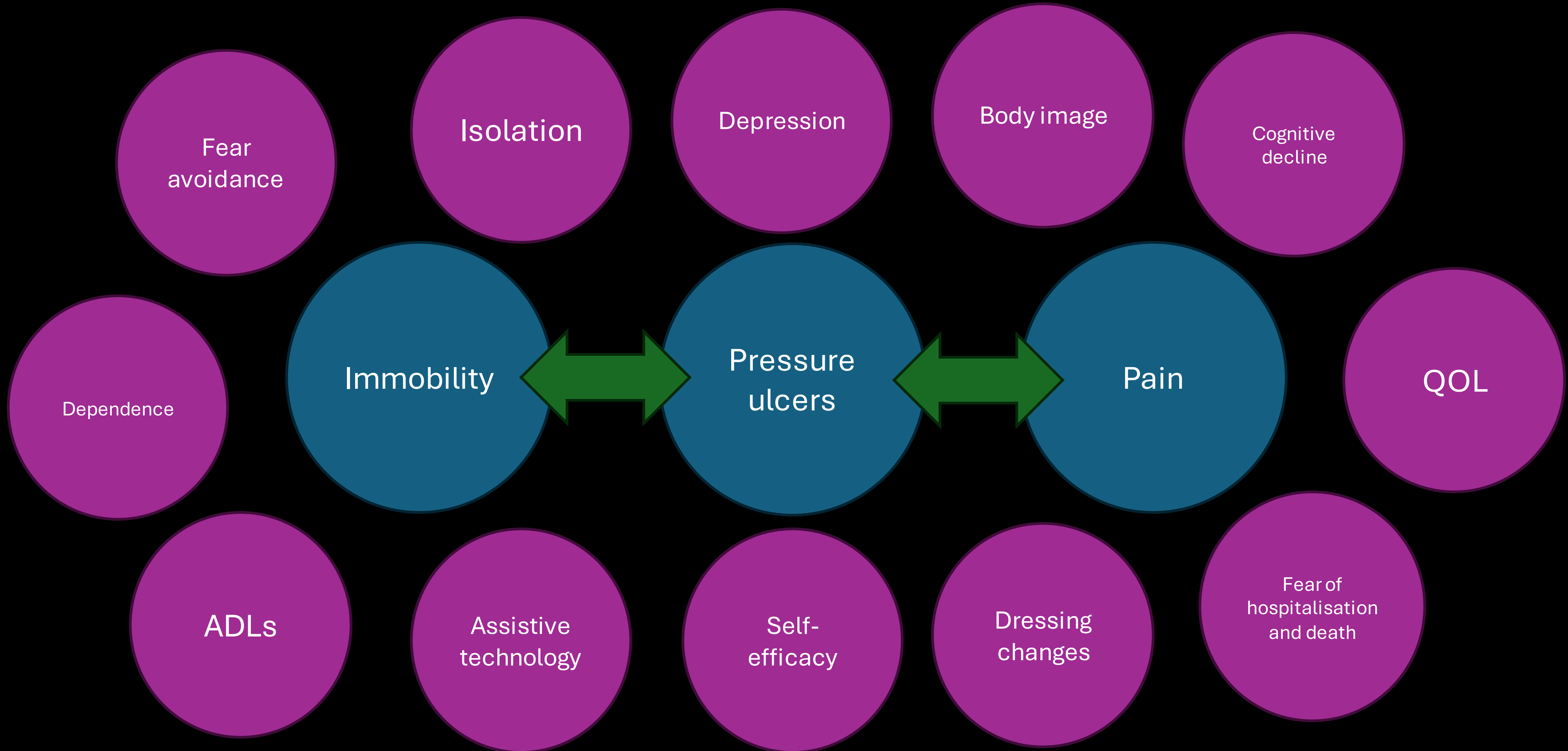
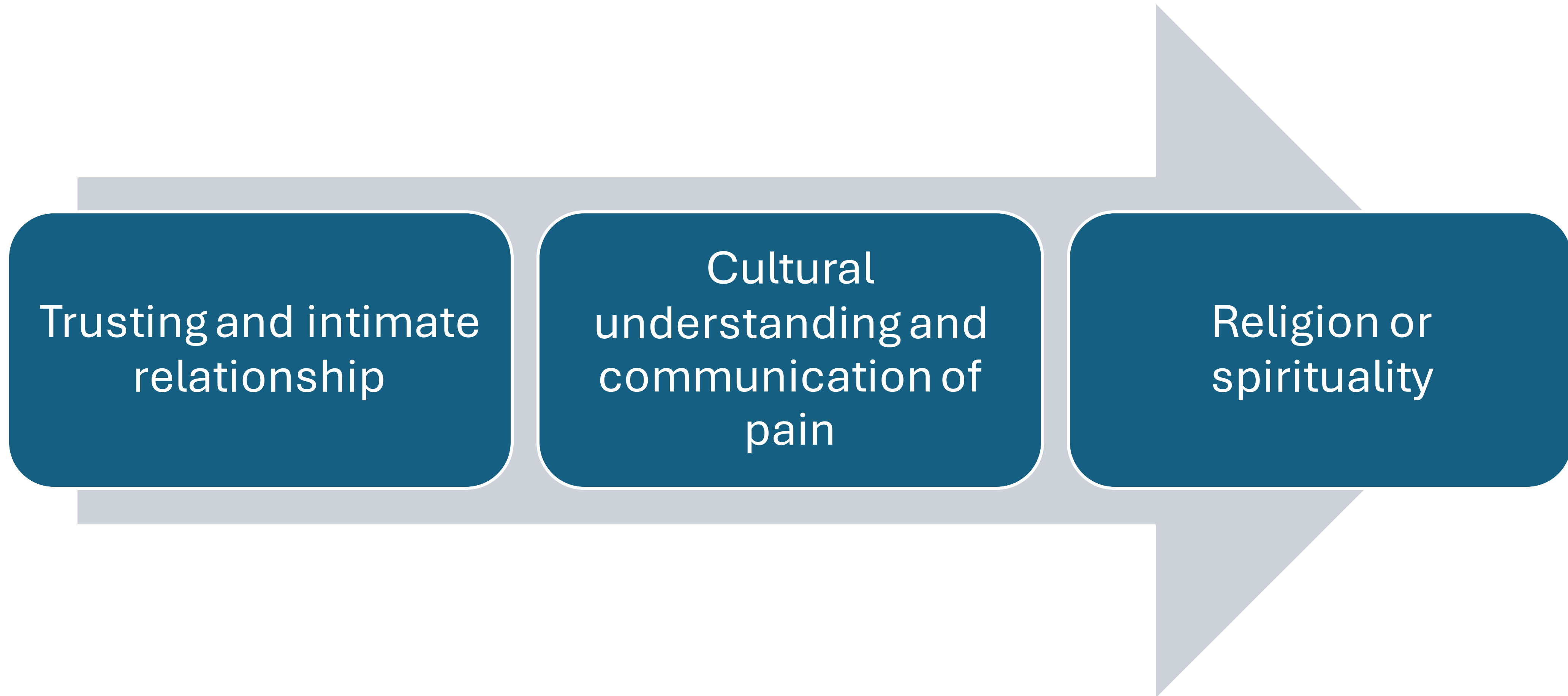


3. Underestimate the impact of pressure ulcers.



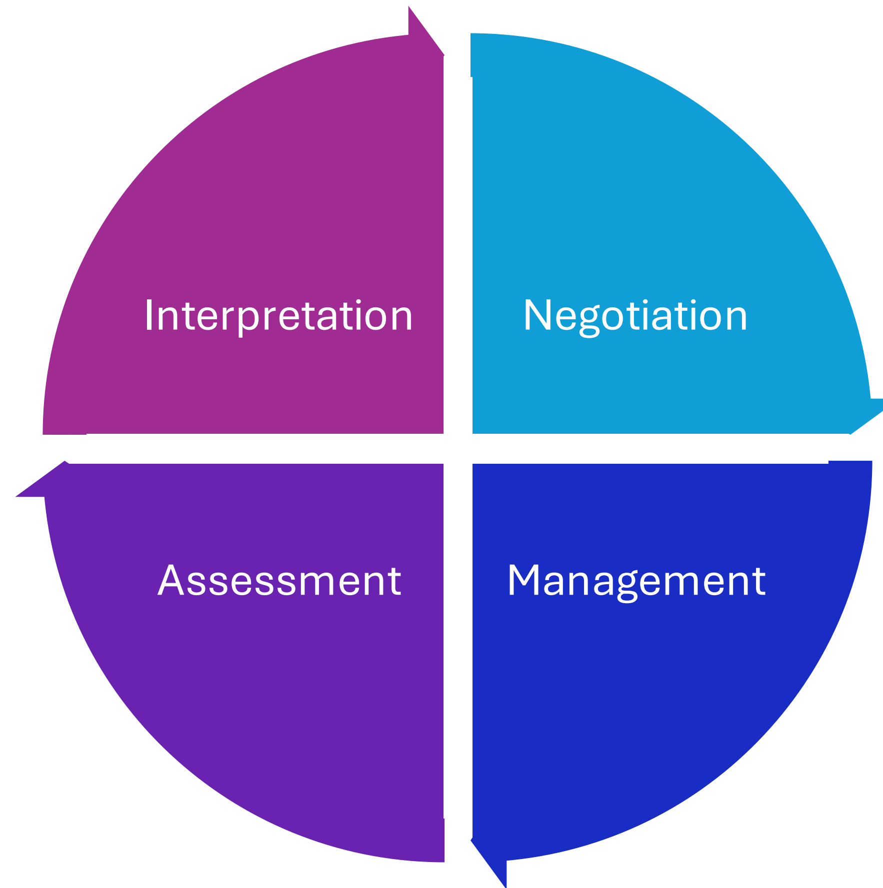
3. Ignore beliefs and attitudes that drive pain behaviour

4. Fail to consider your own beliefs and attitudes



How to win at pain
management

Bringing it all together



Assessment

Site	Onset	Character	Radiation	Alleviating factors and associated symptoms	Time/duration	Exacerbating factors	Severity
•Where is the pain? •Is it diffuse or localised?	•How long have you had it? •Did it come on suddenly or gradually? •Has it got worse or better over time? •What caused the pain in the first place?	•What does the pain feel like?	•Is the pain in one place or does it move about? •Are there any shooting pains associated with it?	•What helps the pain? •How much does that help the pain? •Is the benefit consistent? •How often do you use that strategy? •What other symptoms do you have e.g. poor sleep, anxiety, depression – and how do they affect you?	•How does the pain change over the course of the day? •Is it always the same? •What is the pain like at night? •Overtime is the pain getting better or worse?	•What makes the pain worse? •How much worse? •What does the pain stop you from doing?	•How bad is the pain? Link this in with all the other questions. •What is the worst pain you get? When does that happen? •What is the least pain you have had this week? What do you think helped you at that time? •What is your average daily pain? •What level of pain do you think is acceptable?

Assessment

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

Q1. Vocalisation (eg whimpering, groaning, crying)
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q2. Facial expression (eg looking tense, frowning, grimacing, looking frightened)
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q3. Change in body language (eg fidgeting, rocking, guarding part of body, withdrawal)
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q4. Behavioural change (eg ↑ confusion, refusing to eat, alteration in usual pattern)
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q5. Physiological changes (eg temp, pulse/BP outside normal limits, perspiring, flushing, pallor)
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Q6. Physical changes (eg skin tears, pressure areas, arthritis, contractures)
Absent 0 Mild 1 Moderate 2 Severe 3 ☐

Total pain score ☐

Tick the box that matches the total pain score

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

Tick the box that matches the type of pain

Chronic	Acute	Acute on chronic

Abbey, J 'Ageing, Dementia and Palliative Care' in O'Connor, M and Aranda, S (Eds) 2003 Palliative Care Nursing . A guide to practice , Ausmed Publications, Melbourne, pp. 313-339 (the pain scale is on page 323).
Jennifer Abbey, Neil Piller, Anita De Bellis, Adrian Esterman, Deborah Parker, Lynne; Giles and Belinda Lowcay (2004) The Abbey pain scale: a 1-minute numerical indicator for people with end-stage dementia , *International Journal of Palliative Nursing*, Vol 10, No 1 pp 6-13.

Assessment

Disability Distress Assessment Tool

Client's name:
DoB: Gender:
Unit/ward: NHS No:
Your name: Date completed:
Names of others who helped complete this form:

INFORMATION AND INSTRUCTIONS ARE ON THE BACK PAGE

Facial appearance when CONTENT	Facial appearance when DISTRESSED
Face	Face
Tongue/jaw	Tongue/jaw
Eyes	Eyes

Vocal signs when CONTENT	Vocal signs when DISTRESSED
Sounds	Sounds
Speech	Speech

Habits and mannerisms when CONTENT	Habits and mannerisms when DISTRESSED
Habits	Habits
Mannerisms	Mannerisms
Comfortable distance	Comfortable distance

Posture & observations when CONTENT	Posture & observations when DISTRESSED
Posture	Posture
Observations	Observations

Context of distress and communication/action which helps ease distress
(You can record either a specific episode, using dates, or just describe what usually causes this person to be distressed)

Date	Context of distress	Actions that can alleviate distress

VOCAL SOUNDS (NB. The sounds that a person makes are not always linked to their feelings)

Information / instructions	Sounds when content	Sounds when distressed
Ring the words that best describe the sounds *Write down* commonly used sounds (write it as it sounds; 'tizz', 'eeiow', 'tetetetete'):	**Volume:** high medium low **Pitch:** high medium low **Duration:** short intermittent long **Description of sound / vocalisation:** Cry out Wail Scream Laugh Groan / moan Shout Gurgle Other:	**Volume:** high medium low **Pitch:** high medium low **Duration:** short intermittent long **Description of sound / vocalisation:** Cry out Wail Scream Laugh Groan / moan Shout Gurgle Other:

SPEECH

Information / instructions	Words when content	Words when distressed
Write down commonly used words and phrases. If no words are spoken, write NONE		
Ring the words which best describe the speech	Clear Stutters Slurred Unclear Muttering Fast Slow Loud Soft Whisper Other:	Clear Stutters Slurred Unclear Muttering Fast Slow Loud Soft Whisper Other:

HABITS & MANNERISMS

Information / instructions	Habits and mannerisms when content	Habits and mannerisms when distressed
Write down the habits or mannerisms		
Write down any special comforters, possessions or toys this person prefers.		
Please Ring the statements which best describe how comfortable this person is with other people being physically close by	Close with strangers Close only if known No one allowed close Withdraws if touched	Close with strangers Close only if known No one allowed close Withdraws if touched

BODY POSTURE

Information / instructions	Posture when content	Posture when distressed
Ring the words that best describe how this person sits and stands.	Normal Rigid Floppy Jerky Slumped Restless Tense Still Able to adjust position Leans to side Poor head control Way of walking: Normal / Abnormal Other:	Normal Rigid Floppy Jerky Slumped Restless Tense Still Able to adjust position Leans to side Poor head control Way of walking: Normal / Abnormal Other:

BODY OBSERVATIONS

Information / instructions	Observations when content	Observations when distressed
Describe the pulse, breathing, sleep, appetite and usual eating pattern, eg. eats very quickly, takes a long time with main course, eats puddings quickly, "picky".	Pulse: Breathing: Sleep: Appetite: Eating pattern:	Pulse: Breathing: Sleep: Appetite Eating pattern:

FACIAL SIGNS Appearance

Information / instructions	Appearance when content	Appearance when distressed
Ring the words that best describe the facial appearance	Passive Laugh Smile Frown Grimace Startled Frightened Other:	Passive Laugh Smile Frown Grimace Startled Frightened Other:

Jaw movement

Information / instructions	Movement when content	Movement when distressed
Ring the words that best describe the jaw movement	Relaxed Drooping Grinding Biting Rigid Other:	RelaxedDrooping Grinding Biting Rigid Other:

Appearance of eyes

Information / instructions	Appearance when content	Appearance when distressed
Ring the words that best describe the appearance	Good eye contact Little eye contact Avoiding eye contact Closed eyes Staring Sleepy eyes 'Smiling' Winking Vacant Tears Dilated pupils Other:	Good eye contact Little eye contact Avoiding eye contact Closed eyes Staring Sleepy eyes 'Smiling' Winking Vacant Tears Dilated pupils Other:

SKIN APPEARANCE

Information / instructions	Appearance when content	Appearance when distressed
Ring the words that best describe the appearance	Normal Pale Flushed Sweaty Clammy Other:	Normal Pale Flushed Sweaty Clammy Other:

Clinical decision distress checklist

Use this to help decide the cause of the distress

Is the new sign or behaviour?

- **Repeated rapidly?**
  Consider pleuritic pain (in time with breathing)
  Consider colic (comes and goes every few minutes)
  Consider: repetitive movement due to boredom or fear.
- **Associated with breathing?**
  Consider: infection, COPD, pleural effusion, tumour
- **Worsened or precipitated by movement?**
  Consider: movement-related pains
- **Related to eating?**
  Consider: food refusal through illness, fear or depression
  Consider: food refusal because of swallowing problems
  Consider: upper GI problems (oral hygiene, peptic ulcer, dyspepsia) or abdominal problems.
- **Related to a specific situation?**
  Consider: frightening or painful situations.
- **Associated with vomiting?**
  Consider: causes of nausea and vomiting.
- **Associated with elimination (urine or faecal)?**
  Consider: urinary problems (infection, retention)
  Consider: GI problems (diarrhoea, constipation)
- **Present in a normally comfortable position or situation?**
  Consider: pains at rest, infection, nausea, anxiety, depression, anger.

Distress may be hidden, but it is never silent

Promote wound healing

- Nutrition and hydration
- Mobility
- Pressure off-loading
- Safety and fear management
- Electrical stimulation

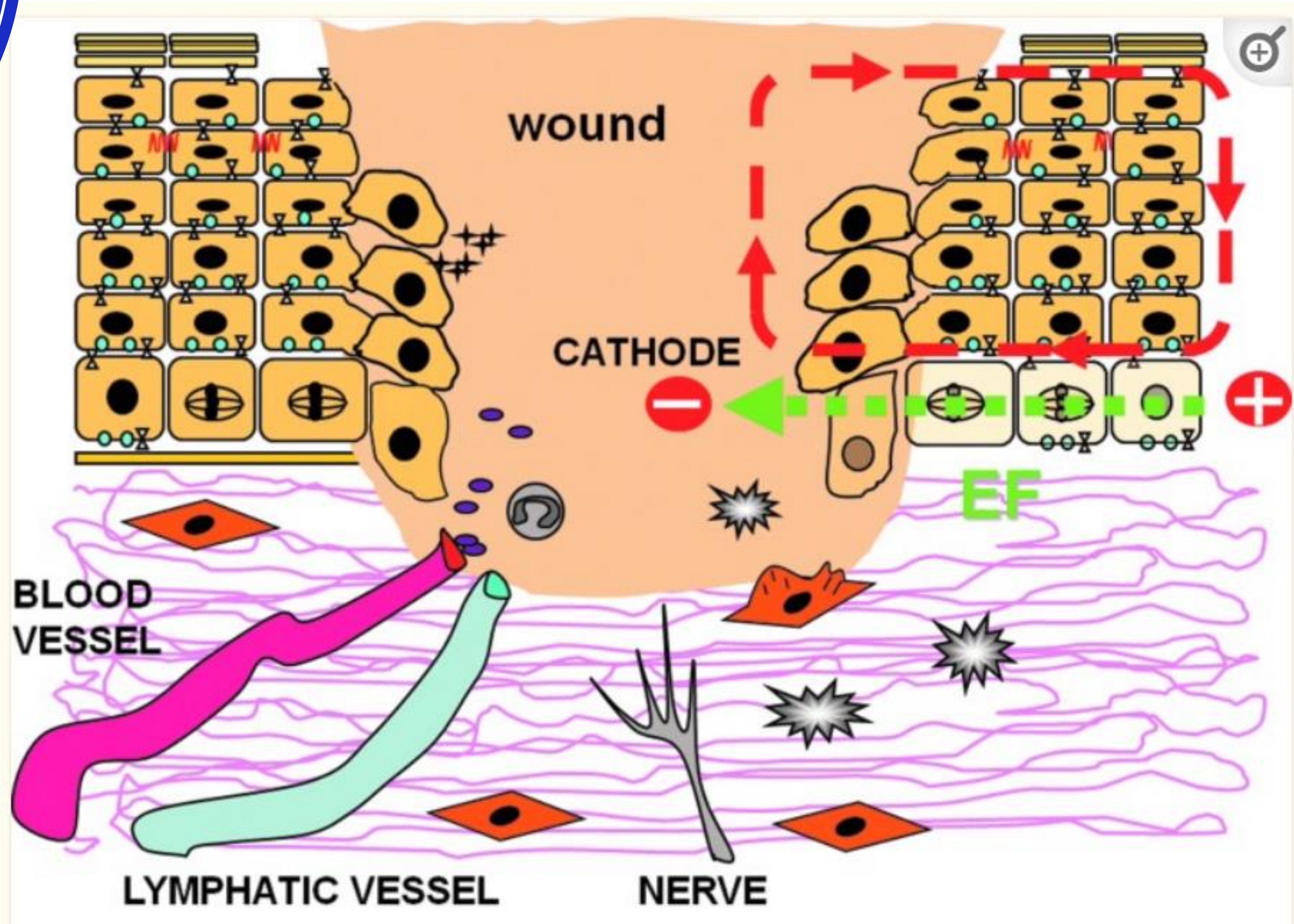
Manage psychological and social impacts

- Be cognisant of impact of smell and exudate.
- Maximise dignity.
- Encourage social interaction.
- Listen and empower.

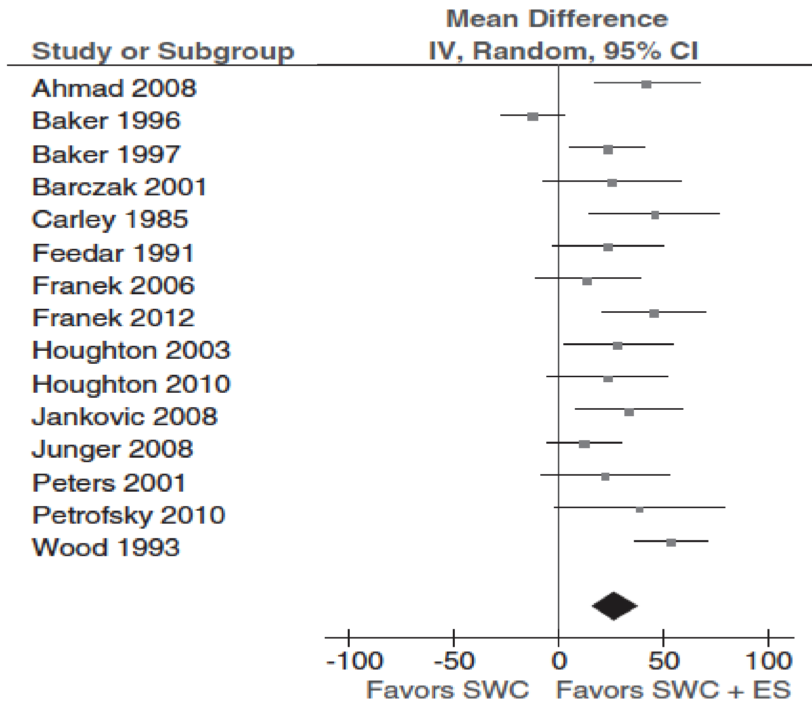
Pain reduction and recovery

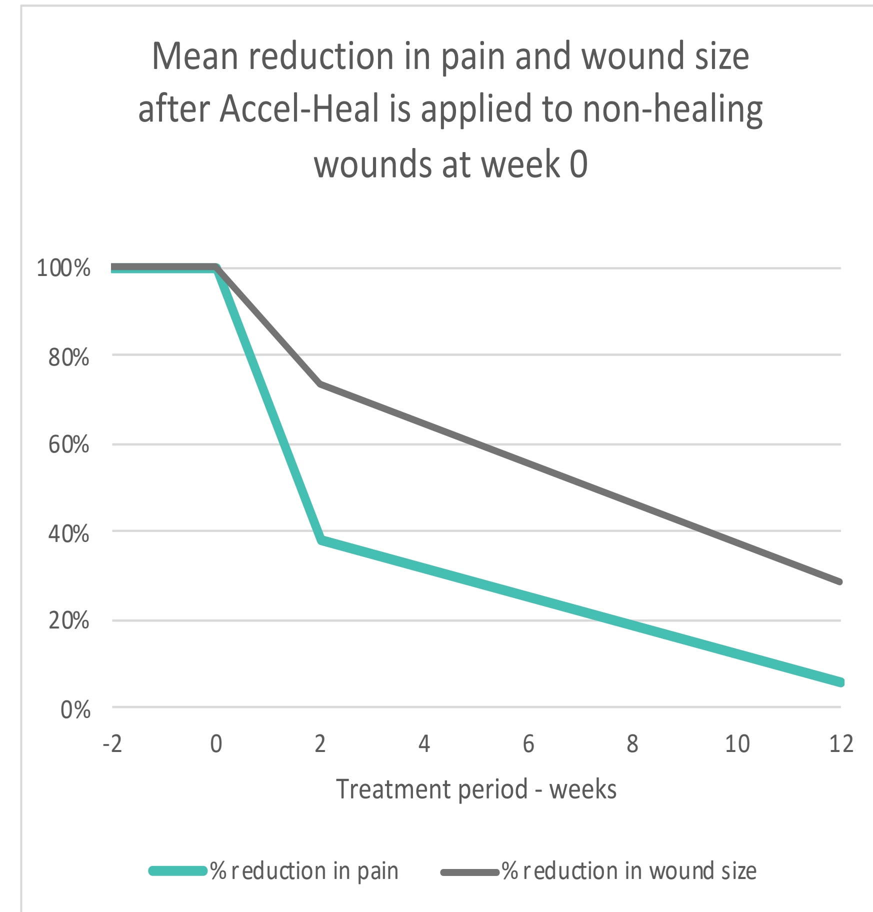
- Analgesia has limited impact and many side effects.
- Consider complementary therapies for wellbeing and pain relief.
- Consider electrical stimulation.

Management



Electrical stimulation promotes wound healing and reduces pain

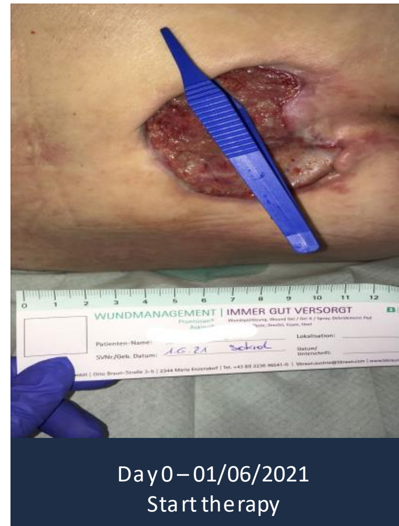




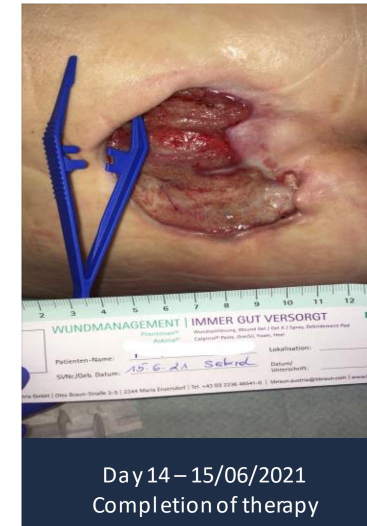
Koel & Houghton (2014). "Electrostimulation: Current Status, Strength of Evidence Guidelines, and Meta-Analysis." *Advances in Wound Care* 3 (2): 118–26. http://www.ncbi.nlm.nih.gov/pubmed/24761352
Ovens L (2022). What is the role of electrical stimulation therapy. Wound Masterclass Vol 1 June 2022.

ACCEL-HEAL FOR A LONG-STANDING PRESSURE INJURY/ULCER [1]

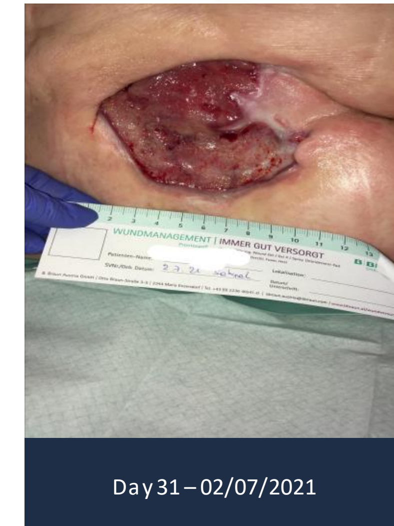
- 70 year old female with multiple sclerosis and bed-bound for over 5 years
- Recurrence of pressure injury/ulcer following hospitalization 3 years previously
- History of several wound infections
- Commenced Accel-Heal on 01/06/21
- Pain score 5/10 (VAS)
- By end evaluation (day 31)
    - the wound depth had decreased by 60%
    - Level of exudate completely reduced
    - Epithelization from the edges
    - Pain score reduced to 2/10 (VAS)
    - Wound environment much softer



Day 0 – 01/06/2021
Start therapy

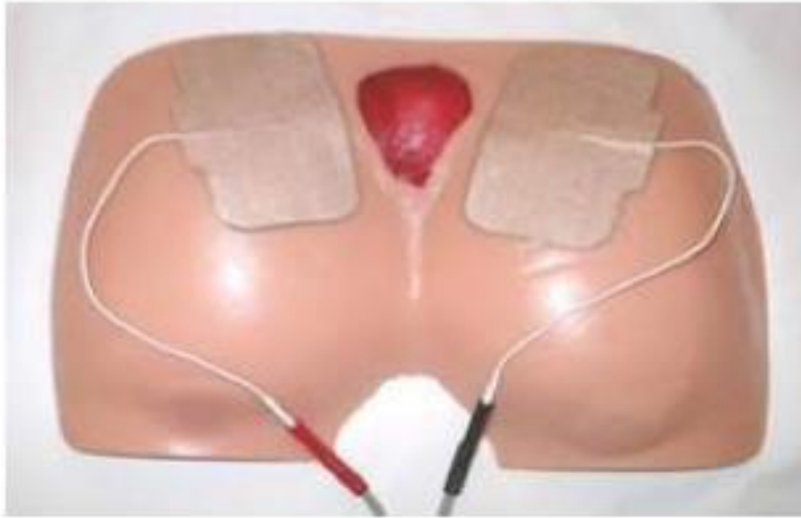


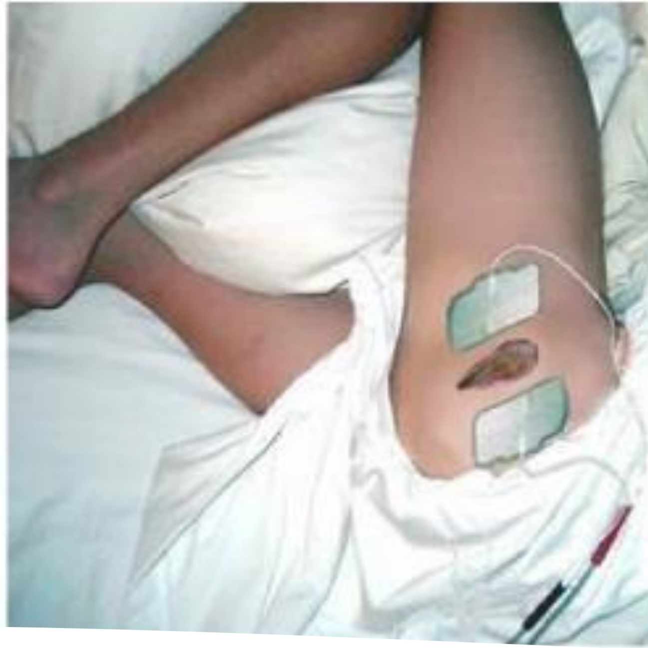
Day 14 – 15/06/2021
Completion of therapy

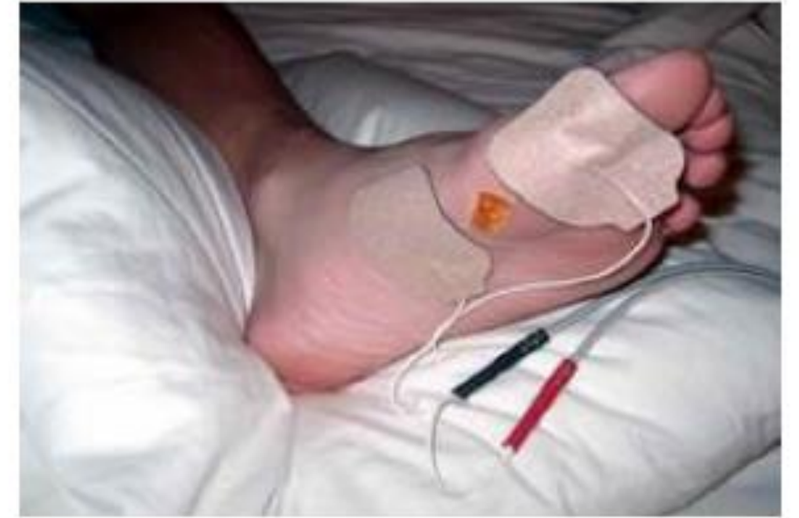


Day 31 – 02/07/2021

.1. Kurz et al (2022) (Poster publication at EWMA 2022). Clinical evaluation of the response rate to a continuously active, single-use electrical stimulation device in static non-healing wounds.







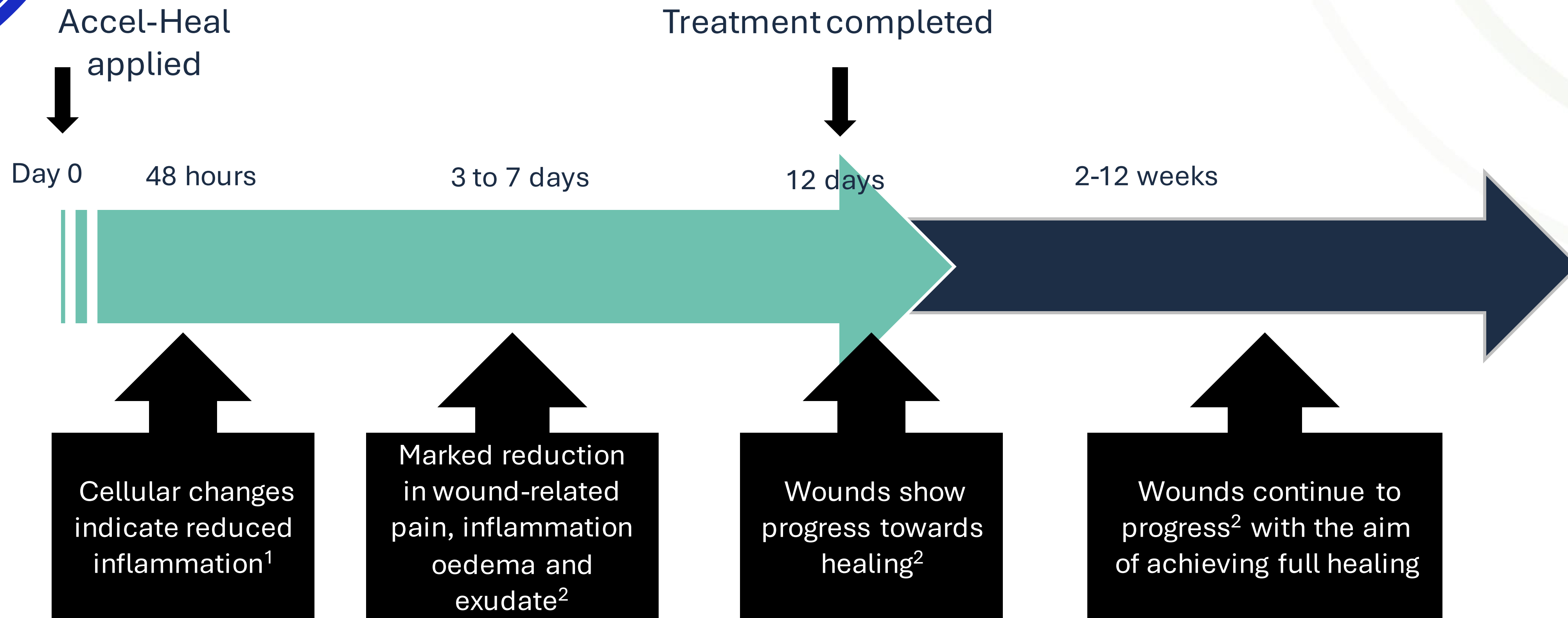
Electrical stimulation - TENS

1. Stimulation of large diameter (A-Beta) fibres
2. Decreasing inflammation-induced dorsal horn sensitisation via release of endorphins
3. Increasing levels of inhibitory neurotransmitters (GABA and glycine)
4. Modulation of glial cells

Picture from: https://blog.acplus.com/healing-chronic-wounds-faster-with-electrical-stimulation - Accelerated Care Plus

Management

What to expect when using electrical stimulation



Based on a clinicians assessment, further periods of 12-days therapy can be used

1. Lallyett et al (2018). Changes in S100 Proteins Identified in Healthy Skin following Electrical Stimulation: Relevance for Wound Healing. *Advances in Skin & Wound Care*, *31*(7), 322–327
2. Milne, Jeanette, Amelia Swift, Jennifer Smith, and Robin Martin. 2021. “Electrical Stimulation for Pain Reduction in Hard to Heal Wound Healing.” *Journal of Wound Care* 30(7):568–80.

Nociceptive pain management

- Paracetamol
- Ibuprofen and diclofenac
- Opioids
- Lidocaine
- Curcumin (part of turmeric)
- Cannabis
- Electroceutical

Neuropathic pain management

- 2 weeks of either
- Duloxetine 30-60mg BD
- Amitriptyline 25-75mg nocte

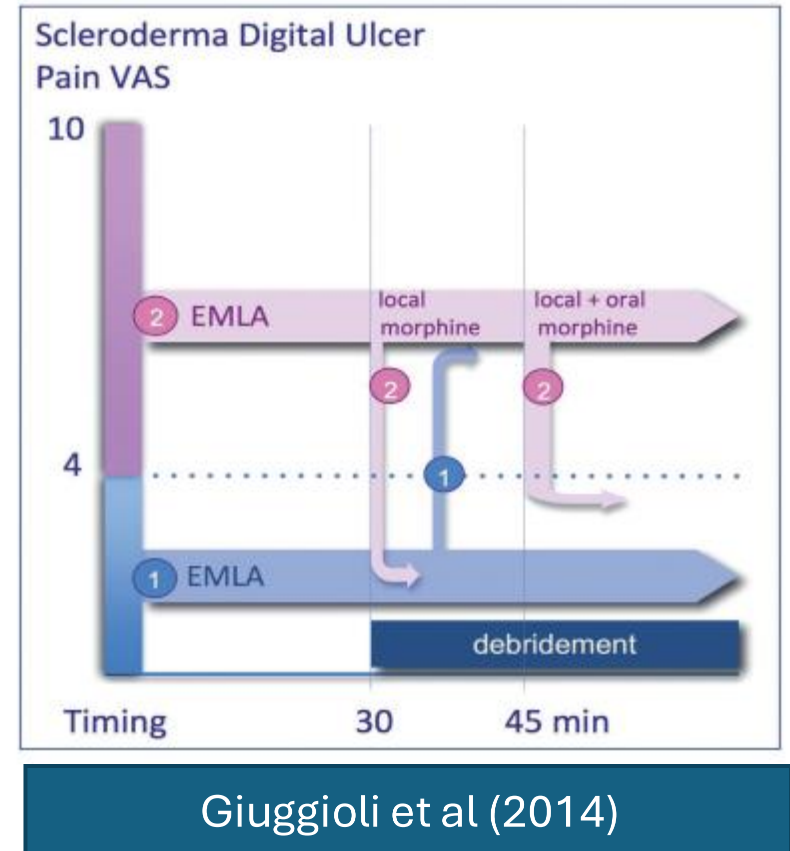
- ADD if necessary
- Pregabalin 75-300mg BD
- (Gabapentin)

- Ketamine?

Procedural pain

- Prepare

- Pain<4/10: local anaesthetic 30min
- Pain>4/10
  - Local anaesthetic + topical morphine
  - Local anaesthetic + topical morphine + oral morphine



Giuggioli et al (2014)

So what can we do?

? Reiki

☑Acupuncture for pain

☑Acupuncture for healing

☑Chinese herbal medicine

? Reflexology

Priorities:
Pressure off-loading.
Prevent infection.
Accelerate wound healing.

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Pain assessment:
Remember fear, anxiety, and depression.

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Promote:
Movement, self-efficacy,

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Pain assessment:
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Promote:
Movement, self-efficacy,

Preferences:
What has worked?
What are your thoughts?
What can you do?

Priorities:
Pressure off-loading.
Prevent infection.
Accelerate wound healing.

Pain assessment:
Remember fear, anxiety, and depression.

Promote:
Movement, self-efficacy,

Preferences:
What has worked?
What are your thoughts?
What can you do?

Proof:
Simple non-pharmacological measures.
Speed wound healing.
Careful movement.
Promote any independent possible.
Keep your client central to decision-making.