POSITION STATEMENT:

Pain Management in Aged Care

1st Edition

(March 2024)

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Contents

INTRODUCTION **3**

WHY HAS THIS POSITION STATEMENT ON PAIN MANAGEMENT IN AGED CARE BEEN DEEMED NECESSARY/IN NEED OF BEING DEVELOPED? **4**

WHAT DOES PAIN MANAGEMENT IN AGED CARE ENTAIL? **5**

IDENTIFICATION/ASSESSMENT 5
TREATMENT 5
Pharmacological treatments *6*
EVALUATION OF THERAPEUTIC OUTCOMES 6
SPECIAL CONSIDERATIONS 6

WHEN SHOULD PAIN MANAGEMENT IN AGED CARE BE APPLIED? **7**

HOW SHOULD PAIN MANAGEMENT IN AGED CARE BE PROVIDED? **7**

WHO SHOULD BE PROVIDING PAIN MANAGEMENT SERVICES IN AGED CARE? **7**

SUMMARY **8**

CONTRIBUTORS **8**

REFERENCES **9**

APPENDICES **11**

APPENDIX 1: DEFINITIONS 11

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Introduction

Older adults are particularly vulnerable to unresolved pain. They may fail to report pain due to the belief that it is a normal consequence of ageing, fear of intervention or loss of independence, adverse effects of analgesia, fear of addiction or acceding to the wishes of family or medical staff. Pain is a predominant feature in older adults and is often under-recognised and poorly treated. Access to pain management is a fundamental human right [(1)] and there is an obligation on all healthcare professionals to identify those with unrelieved pain and to relieve suffering [(2).]

The older person living with pain as a percentage of patients living with pain, is an expanding segment of the Australian population. It is estimated that the number of Australians aged 85 years and older will increase to more than 1.5 million by 2058 from 515,700 in 2018-19. With advanced age comes increased frailty and dementia and the demand for aged-based care services will also increase. [(3)(4)(5)]

Acute pain is also becoming more common as the population ages e.g., arthritis, osteoporotic spinal fractures, cancer and conditions such as herpes zoster, peripheral vascular disease, ischaemic heart disease, and trauma. Advances in anaesthetic and surgical techniques also mean that increasingly older patients are undergoing surgery, hence the need for specialist skills and interventions [(6)]. The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) [(2)] endorsed the Australian and New Zealand College of Anaesthetists (ANZCA) Peri-operative Care Framework [(7)] and has also developed a position paper on perioperative care of older people.

One in five Australians are estimated to live with chronic (persistent) pain and disability [(8)] and this number increases to one in three adults over the age of 65 [(7)]. It is further estimated that between 80-93% of residents in aged care facilities experience pain which is poorly recognised and often undertreated [(2)(4) (7) (8) (9)].

Pain is best understood through a biopsychosocial framework [(6)(7)(8)(9) (10)] with the assessment process identifying pain contributors being essential. This applies to all types of pain, whether acute, chronic (persistent) or in the end-of-life setting. To improve pain management outcomes and reduce suffering, health care workers and professionals, government and society need to:

- Understand the breadth of the problem of pain in older people
- Develop an understanding of the many potential contributors to a person's pain within a biopsychosocial model of pain care
- Develop an understanding of the need for a team-based approach to the management of pain in older people
- Appreciate the responsibility that aged care facilities and home based aged care providers must provide adequate pain management for individuals with pain

- Apply effective pain management strategies through all stages of the aged care journey
- Understand how to develop strategies, pathways and procedures which align with the Aged Care Quality Standards in provision of effective pain management in the aged (11)

Why has this position statement on pain management in aged care been deemed necessary/in need of being developed?

The Australian Pain Society (APS) wishes to promote a person-centred multidisciplinary and interdisciplinary approach to the assessment and management of pain in the older person. This document is to be used in conjunction with our seminal publication “Pain in Residential Aged Care Facilities: Management Strategies Second Edition” (9) which outlines care requirements for the older person in pain in more detail.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) was tasked with an urgent review of the quality standards in aged care in response to the Royal Commission into Aged Care Quality and Safety (12). The Commission sought feedback from key stakeholders including the APS on the development of the NSQHC Aged Care Module. Whilst pain and its management were acknowledged as an important clinical care issue, it was not included as a priority clinical care standard in its own right. Evidence suggests that poorly controlled pain is associated with functional impairment, frailty, and poor health outcomes. This translates to immobility, falls risk, pressure injury development, incontinence due to the inability to mobilise to the bathroom, depression and other mood changes and reduced food and nutritional intake. Effective person-centred pain management aims to provide relief and comfort and will improve overall quality of life. (12)(13)(14)(15)

The APS recognises the gap and barriers in pain management in the aged care sector. Beliefs and attitudes about pain and its management, expectations, memory and learning, stigma attached to chronic pain, cultural norms and expectations, socioeconomic status and genetic, physiological and immunological responses are some examples of the dimensions of the pain experience. When these factors are combined with deficits in healthcare worker education and training, increased workload and inadequate staffing and funding issues, these barriers are further entrenched. (7)(8)(9)(10)(16)

Healthcare workers require education and training to assess and manage pain in older people, especially those with complex pain problems and in aged care facilities. Attitudinal barriers in patients, carers and health care workers need to be examined and addressed, as does the fact that pain perception and processes are not reduced in those suffering from

dementia - the inability to articulate the presence and severity of their pain must not be seen as a denial of the presence of pain. [2][8][9][10][12][15][16][17].

Examination of funding and resource issues within the aged care sector are beyond the scope of this document. However, the lack of access to and reimbursement for appropriately qualified allied health practitioners in the sector adversely affects the quality of care provided. Shifting decision making from allied health professionals to aged care providers fails to support the older person to preserve or restore their independence and capacity for dignified living. The provision of adequately trained and appropriately staffed services is integral to improvements in care delivery. The health care team need to have access to and be supported by technological resources including electronic medical records and discharge summaries, health care plans and advanced care directives, national inpatient medication charts and prescribing software, real time prescription monitoring systems, online education material such as painACT and documents and reporting instruments as required by regulatory and accreditation bodies.

The APS emphasises the ethical obligation to identify and treat unrelieved pain and to advocate for better pain management in all aspects of aged care (primary care, home based/community care, hospital inpatient and in residential care facilities).

What does pain management in aged care entail? [9][10][11][16][17]

Identification/Assessment

The healthcare facility should encourage a vigilant approach to pain management, emphasising the need for timely identification of pain in individuals, especially older adults. Staff are urged to be attentive to various indicators that may signal pain expression in older patients. Routine pain assessments are advised upon admission, after incidents like falls or medical procedures, during changes in health status, and periodically, with more frequent checks for advanced dementia patients.

When conducting pain assessments, the goal is to measure pain accurately using methods best understood by the patient, assessing pain during rest and activity, and taking responsive actions based on the assessment findings. A comprehensive pain history, alongside a general medical evaluation and consideration of psychosocial and functional impacts, is recommended. This includes a review of medications, treatment plans, and awareness of cultural and spiritual factors affecting pain management.

Treatment

All pain treatment plans should be tailored to the individual's needs and preferences.

Pain treatments encompass a multifaceted approach, integrating various strategies to address discomfort. Comfort measures constitute a fundamental aspect, encompassing hygiene, positioning, and the application of heat or cold. Spiritual and cultural care also play roles in providing comfort. Non-pharmacological interventions involve a collaboration with allied health professionals.

Moreover, complementary and alternative medicine, such as acupuncture, massage, Tai Chi, and yoga, are integrated into treatment plans. Education and communication hold significant weight, involving the patient and their family in shared decision-making processes. Discussions encompass setting realistic expectations and goals, acknowledging that complete pain elimination might not be achievable, but emphasising the attainability of making pain tolerable and manageable. Reinforcement of treatments and enhancing health literacy serve as key components of effective pain management strategies.

Pharmacological treatments

Pharmacists are involved in medication reconciliation, identification of drug interactions and adverse effects, minimising polypharmacy, medication reduction and rationalisation, education (older person and health care worker), research and quality assurance activities in addition to supplying and dispensing prescribed medications. Medications may include over the counter or prescribed analgesics, adjuvant therapies and evidence-based nutraceuticals. Interventions and procedural management may be appropriate and provide adequate relief for functional improvement, whilst self-management strategies are progressively implemented.

Evaluation of therapeutic outcomes

The treatment approach for individuals experiencing pain emphasises collaboration among a multidisciplinary team, the individual, and their family. Treatment plans should be jointly developed and regularly assessed for effectiveness, noting any obstacles to adherence, and suggesting necessary adjustments. Effective communication among all team members is vital for optimal care. Pain assessment tools are advocated for evaluation purposes, while specific measures such as psychometric questionnaires, functional assessments, and nutritional evaluations will be employed by healthcare professionals to gauge outcomes. All care and outcomes are to be carefully documented in compliance with legislative and governmental standards, including those outlined in the Aged Care Standards.

Special considerations

It is important to recognise some groups may need extra consideration when experiencing pain. People from culturally and linguistically diverse backgrounds,

Aboriginal and Torres Strait Islanders, those who identify as gay, lesbian, transgender or intersex, those who have experienced significant trauma or who have developed post-traumatic stress disorder, and people with disability are at a greater risk of heightened pain sensitivity due to different life experiences. It is important to be sensitive to the needs of these groups and ensure that a comprehensive plan is developed to assist with their pain management.

Older people nearing the end of life require physical, spiritual, and psychological support. The early identification of the person's transition to the end stages of life will ensure appropriate and timely intervention and the provision of comfort care and analgesia as required.

Ongoing education and training for health professionals and care workers is vital if pain management in older people is to be improved.

When should pain management in aged care be applied?

Pain assessment and management should be applied whenever the presence of pain is identified or suspected. Pain assessment should be part of routine care and assessments and plans developed and revised on a regular basis (as mentioned above in section 3)

How should pain management in aged care be provided?

Pain management in aged care should be person centred, multidisciplinary in approach and be based on a biopsychosocial framework. Treatment plans are to be developed in consultation with the person and their family, be structured and include effective interdisciplinary communication. Regular reassessment and evaluation of outcomes is vital to success.

Appropriate funding, education and resources should be provided.

Who should be providing pain management services in aged care?

The following list of care providers includes, but is not limited to:

- General practitioners, geriatricians, rehabilitation consultants, psychiatrists, pain medicine physicians and palliative medicine physicians.

- Pharmacists
- Nurses (enrolled, registered, nursing unit managers, clinical nurse consultants and nurse practitioners)
- Personal care assistants
- Physiotherapists
- Exercise physiologists
- Occupational therapists
- Psychologists
- Diversional therapists
- Dieticians
- Massage therapists
- Counsellors
- Social workers
- Hand therapists
- Podiatrists

Summary

Management of pain in the older person is multifaceted and can involve many interventions and providers of care. The development of a pain management plan is not a static process. The plan must be developed in consultation with the person living with pain and their voice must be listened to. The plan should be revisited regularly, and adjustments made as needed. Effective and timely communication between all providers of care is essential to ensure optimal care is achieved.

The Australian Pain Society's publication 'Pain in Residential Aged Care Facilities: Management Strategies, Second Edition' is a comprehensive guide to the management of pain in the older person. This reference and tools are applicable across the aged care sector – home and community based, primary care and residential aged care.

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Appendices

Appendix 1: Definitions

Acute pain:

- In brief: Pain related to an injury or disease of less than 3 months [9]
- Acute pain happens suddenly, starts out sharp or intense, and serves as a warning sign of disease or threat to the body. It is caused by injury, surgery, illness, trauma or painful medical procedures and generally lasts from a few minutes to less than six months. Acute pain usually disappears whenever the underlying cause is treated or healed. [18]
- Considered to last up to 7 days, with the following qualifications:
  Its duration reflects the mechanism and severity of the underlying inciting event,
  Prolongations from 7-30 days are common.
  Prolongation beyond the duration of acute pain but not extending past 90 days post onset/injury are common. This refers to the ill-defined but important period of "subacute pain" that warrants further specification and consideration in future taxonomic, research and regulatory efforts.
  Our understanding of pain mechanisms is currently insufficient to link these durations to specific physiologic mechanisms. [6]

Chronic pain (also known as persistent pain)

- Pain which lasts for more than 3 months, or in many cases, beyond normal healing time. It is a complex condition, and everyone experiences it differently. The pain can range from mild to severe and is usually experienced on most days. [19] [20]

- The IASP has developed a taxonomy of chronic pain which includes categories such as chronic primary pain, chronic cancer-related pain, chronic postsurgical pain, chronic secondary musculoskeletal pain, chronic secondary visceral pain, chronic neuropathic pain and chronic secondary headache or orofacial pain. [21]

Comfort care:

- Often used interchangeably with palliative care or hospice. Refers to care that improves the quality of life by relieving suffering and providing practical, emotional and spiritual support. [22]

Frailty

- Is a state of vulnerability to poor resolution of homeostasis after a stressor event and is a consequence of cumulative decline in many physiological systems during a lifetime and which increases the risk of adverse outcomes.
- Is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. [23]

Interdisciplinary treatment

- Multimodal treatment provided by a multidisciplinary team collaborating in assessment and treatment using a shared biopsychosocial model and goals. All working closely together with regular team meetings (face to face or online), agreement on diagnosis, therapeutic aims and plans for treatment and review. [(20)]

Multidisciplinary treatment

- Multimodal treatment provided by practitioners from different disciplines [with] all the professions working separately with their own therapeutic aim for the patient and not necessarily communicating with each other. [(20)]

Multimodal treatment

- The concurrent use of separate therapeutic intervention with different mechanisms of action within one discipline aimed at different pain mechanisms. [(20)]

Pain

- "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." [(20)]

Pain assessment

- Aims to measure pain, understand the cause of pain and how the person experiences pain and is impacted by it. [(10)]
- Is a comprehensive clinical process of describing pain and its associated disability [(24)]
- Is not just a pain score.
- The basis from which treatment plans are developed.

Pain assessment tools

- Tools and scales used to assess the biopsychosocial aspects of pain.
- May be unidimensional such as a verbal numerical rating scale or verbal descriptor scale which measure pain intensity, multidimensional scales such as the Modified Resident's Verbal Brief Pain Inventory (M-RVBPI) which rates the biopsychosocial impacts of pain on activity, mood, relationships with others, sleep and enjoyment of life and observational tools used for older persons who are unable to articulate their pain. Examples are the Abbey Pain Scale and the Pain Assessment in Advanced Dementia (PAINAD) Scales. [(10)]

Pain behaviours

- Actions or behaviours which indicate the person may have pain. Examples include facial expressions (grimacing, frowning), groaning, limping, guarding or protecting an injured part of the body, rubbing a painful area, refusal to move or change position, bracing, rocking, clenched fists, behavioural changes (agitation, irritability, acute confusion).