

# Tips for Nurses: Pain Management



**What it is:** Pain is an unpleasant sensory and emotional experience. This includes physical and spiritual pain.

**Why it matters:** People with advanced disease often experience many types of pain requiring multiple treatment approaches. Registered nurses are responsible for pain assessment.

**What I need to know:** Pain is whatever a person says it is. The feeling and expression of pain will be affected by the person's experience, attitudes, and beliefs. Pain is common in chronic progressive illness, but needs may change as the illness progresses.

Palliative care helps to manage pain and improve quality of life. The principles of pain management remain the same, but palliative care decisions and pain management may be influenced by the person's preferences and values. Refer to their Advance Care Directive (ACD). Alterations to liver and kidney function in older people may affect clearance of medication. Choice of medication may be influenced by a person's preference and capacity e.g., swallowing of oral medications.

Causes of pain include:

- neurological illnesses
- musculoskeletal pain, contractures
- wounds
- vascular disease.

Poorly managed pain can cause:

- a decrease in physical function and appetite
- social isolation
- sleep and rest disturbance
- depression
- family distress
- poor cognitive function
- challenging behaviours and delirium
- increased vocalisation and/or resistance.

Pain identification and assessment in older people:

- requires observation and communication skills
- use of appropriate validated assessment tools
- includes reports from the person, their family and carers to assess pain and response to treatment
- recognises cultural and personal beliefs about pain and includes them in the care plan
- may require consultation with specialists.

## Actions

**Assessments** are repeated regularly to evaluate effectiveness and safety of any treatment. Assessment:

- identifies illnesses and conditions that contribute to pain
- identifies activities that exacerbate pain, or activities that are avoided because they cause pain.

**Assessment** should be undertaken while the older person is moving or being assisted to move. The right assessment tool should be used to monitor the person for any change.

**Careful positioning** of immobile clients or residents can minimise muscle pain and cramps.

**A combination** of pharmacological and non-pharmacological measures, emotional support and psychological interventions may be utilised.

**Clinical assessment** using a multidisciplinary approach can assist with care planning to manage pain.

## Tools

Tools that may be useful.

Choice of assessment tool depends on the person's capacity to respond but includes:

- **Asking if a person has pain** is considered the most reliable indicator of pain
- **Modified Resident's Verbal Brief Pain Inventory (RVBPI)** – for people able to communicate
- **Abbey Pain Scale** – useful if a client is unable to communicate their pain
- **Pain Assessment in Advanced Dementia Scale (PAINAD)**.

**Name:**

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## My reflections:

How many of the people I care for are regularly assessed for pain using an appropriate scale?

Are they re-assessed, and is their care evaluated following changes in their condition?

How many of the people I care for would benefit from use of the Abbey Pain Scale to assess pain?

## My notes:

See related palliAGED Practice  
Tip Sheets:  
Myths about Morphine  
Opioid Analgesics  
Palliative Care

For references and the latest version of all the Tip Sheets visit  
[www.palliaged.com.au/PracticeTipSheets](http://www.palliaged.com.au/PracticeTipSheets)