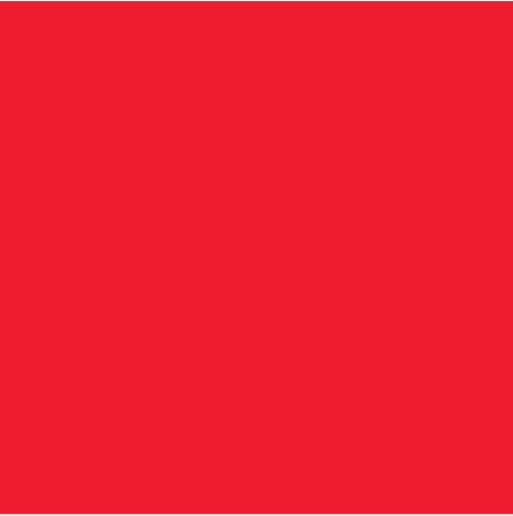




Pain Management Guide (PMG) Toolkit for Aged Care



2nd Edition

**An Implementation Kit to Accompany the Australian Pain Society's book
Pain in Residential Aged Care Facilities: Management Strategies – 2nd Edition**





A catalogue record for this book is available from the National Library of Australia

Pain Management Guide (PMG) Toolkit for Aged Care, 2nd Edition

Published by the National Ageing Research Institute and the Australian Pain Society

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Reference material

The reference book, *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition*, is available for purchase from the Australian Pain Society website: <https://www.apsoc.org.au/publications>

This is the 2nd edition of the PMG Toolkit. The first edition was prepared by Edith Cowan University in 2007.

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DISCLAIMER: This toolkit accompanies the book, *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition* (2019). The reference book combines a review of the best available evidence for multidisciplinary pain management with current clinical and expert practice. This work was prepared by a panel of multidisciplinary clinical experts using the latest information available at the time. It is believed to be reliable. The information provided is not intended to override the clinical expertise of health care professionals and its use is subject to the clinician's judgement and the resident's preference in each case. This is particularly important in relation to prescription medications.

Instructions to use the Pain Management Guide (PMG) Toolkit for Aged Care, 2nd Edition

This toolkit accompanies the book *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition* (which is abbreviated to *Pain in RACF 2nd Ed* in the footnotes). This toolkit can be used as an electronic document and navigated using either the Navigator, the Four Steps to Pain Management Flowchart, or the links embedded in the text. [Printable Resources are available online.](#)



Navigator

Click the headings below to navigate to the relevant section. The Navigator is also included at the start of each section. You can also continue on and read the next section without clicking any links.

[Section A: Toolkit Overview](#)

[Section B: About Pain](#)

[Section C: Systems and Governance](#)

[Section D: Pain Management \(4 Steps\)](#)

[4 Steps to Pain Management Flowchart](#)

You can also use the 4 Steps to Pain Management Flowchart to navigate the toolkit (see page iv for Flowchart). Clicking on the blue, underlined text will take you to the relevant area.

Links embedded in the text

You can also quickly navigate through the PMG Toolkit 2nd Edition by using the clickable links embedded in the text. Links are underlined text.

Searching for specific words or phrases within the toolkit

On a Windows device: ctrl + F

On a Mac device: command + F

On a mobile/tablet device: Use the “find” or “search” function (often a magnifying glass)

Type in the word or phrase to find the exact information you need. For example, you can search for all instances where “pain vigilance” or “opioid” appear in the text.

Printable Resources



Printable Resources have been marked with a printer symbol. All Printable Resources mentioned in the toolkit are freely available online. On page v is a summary list of all the Printable Resources that accompany the toolkit.

Connecting with the reference material

Extra notes are included at the bottom of some pages of the toolkit. These footnotes show where to find further information on the topic.

The chapter titles from *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition* are listed below.

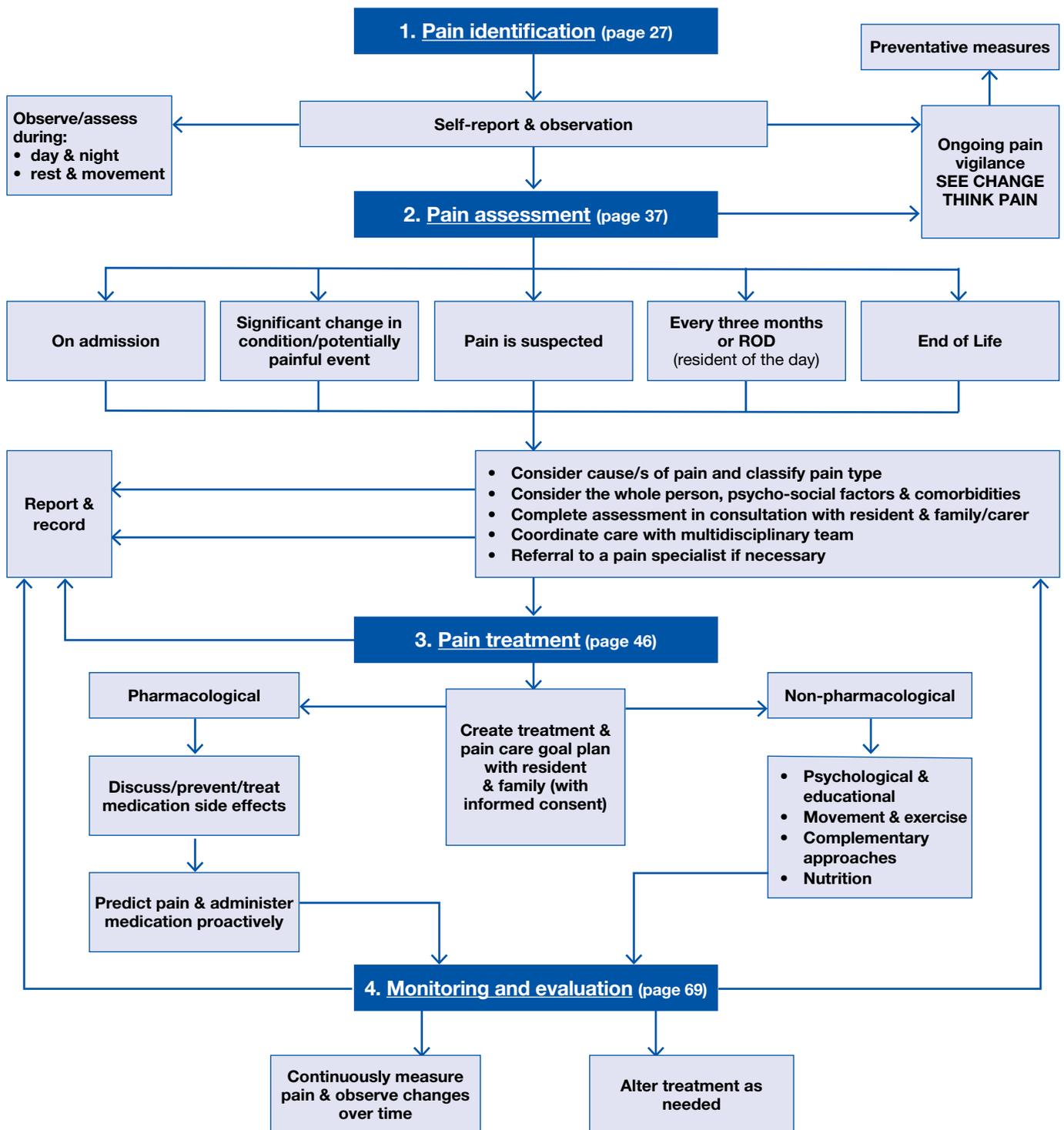
- Chapter 1: About pain
- Chapter 2: Identification and assessment of pain in aged care residents
- Chapter 3: Beyond medication: psychological and education approaches to pain management
- Chapter 4: Movement and physical activity
- Chapter 5: Complementary approaches to pain
- Chapter 6: Pharmacological treatments
- Chapter 7: Dementia and cognitive impairment: special considerations
- Chapter 8: Pain at the end of life
- Chapter 9: Pain and nutrition
- Chapter 10: Quality and systems issues

4 Steps to Pain Management Flowchart

The PMG Toolkit 2nd Edition is built on the 4 steps to pain management. These are:

1. Pain Identification
2. Pain Assessment
3. Pain Treatment
4. Monitoring and Evaluation

Click on the text in the flowchart to be sent to the relevant area in the toolkit. Page numbers are also included if you have printed the document.



Note: Person-centred care should be embedded throughout the pain management process



Ready-made [Printable Resources](#) are available online and free to use in Australian residential aged care facilities. Acknowledgment and attribution must be retained. Click the name of the printable resource in the list below to take you to it.

Systems and governance documents

- [Pain Management Audit Checklist for Residential Care](#)
- [Pain Action Plan for Residential Care](#)

Posters

- [The 4 Steps to Pain Management - Simple](#)
- [The 4 Steps to Pain Management - Detailed](#)
- [Bio-Psycho-Social Factors](#)
- [Pain Management Requires More Than Medication](#)
- [See Change, Think Pain](#)
- [Pain Identification and Assessment Flow Chart](#)

Fact Sheets for particular people or staff

For Residents and Families

- [Fact Sheet 1 - Pain Management in Residential Aged Care](#)
- [Fact Sheet 2 - Opioid Medications](#)

For Aged Care Staff and Health Professionals

- [Fact Sheet 1 - Understanding Pain](#)
- [Fact Sheet 2 - Pain Identification](#)
- [Fact Sheet 3 - Pain Assessment](#)
- [Fact Sheet 4 - Non-Pharmacological Pain Management Strategies](#)
- [Fact Sheet 5 - Pharmacological Pain Management Strategies](#)

For Visiting GPs

- [Fact Sheet - Pharmacological Treatment of Pain](#)

For Care Workers

- [Fact Sheet 1 - Pain and Older People in Residential Care Facilities](#)
- [Fact Sheet 2 - Assessing Pain](#)
- [Fact Sheet 3 - Pain Management without Medicine](#)
- [Fact Sheet 4 - Pain Management with Medicine](#)
- [Fact Sheet 5 - Tips for Reassuring Residents About Their Pain](#)

General handouts

- [Key Principles for Managing Pain in Older People](#)
- [Pain Prevention](#)
- [Causes and Types of Pain](#)
- [How Pain May Affect a Resident](#)
- [Managing Constipation](#)
- [Example Questions to Ask During a Comprehensive Pain Assessment Interview](#)
- [Signs of Pain in Older People](#)
- [The Bio-Psycho-Social Model of Pain](#)
- [The Role of Care Staff in the Pain Management Process](#)
- [Identifying Physical Pain Types](#)
- [Pain in Dementia](#)
- [Pain Management at End of Life](#)
- [The International Classification of Functioning, Disability and Health \(ICF\) Model](#)

Pain assessment scales and templates

- [Summary of the pain assessment scales in this toolkit](#)
- [Pain Care Goal Plan](#)
- [Modified Resident's Verbal Brief Pain Inventory \(M-RVBPI\)](#)
- [Numeric Rating Scale \(NRS\)](#)
- [Verbal Descriptor Scale \(VDS\)](#)
- [Abbey Pain Scale](#)
- [Pain Assessment in Advanced Dementia Scale \(PAINAD\)](#)
- [Pain chart template](#)

Assessing nutritional status

- [Tips for using the Subjective Global Assessment \(SGA\)](#)
- [Subjective Global Assessment scale \(SGA\)](#)
- [Tips for using the Mini-Nutritional Assessment \(MNA and MNA-SF\)](#)
- [Mini-Nutritional Assessment scale \(MNA-SF\)](#)

Other documents

- Complete case studies:
 - [Mario](#)
 - [Margaret \(person living with dementia\)](#)

Introduction

Pain management is a fundamental human right. People in pain have the right to the acknowledgment of their pain and to be informed about how it can be assessed and managed by trained health care professionals.

Pain is not a normal part of the ageing process; however, chronic and persistent pain is common. Most residents living in residential aged care facilities have pain¹. Pain can have a significant detrimental effect on an individual's quality of life and psychological wellbeing by decreasing function, limiting mobility and social interaction, and altering appetite and sleep patterns. People who experience chronic pain can become anxious and depressed.

All residents need to be acknowledged and included in the management of their pain. A person-centred care plan considers the person (and their family), their circumstances, their environment, and the impact that pain is having. Evidence-based tools and treatments are vital for best practice pain management.

Acknowledgements

This toolkit is the culmination of many people's hard work, enthusiasm and commitment. The project was funded by the Commonwealth Department of Health. Firstly, thank you to the health practitioners and pain experts, aged care staff, residents and family members who participated in the development and testing of the toolkit through interviews and a co-design workshop. Thank you to the **advisory committee** for their ongoing support and input: Prof Deborah Parker, Ms Fiona Hodson (on behalf of the Australian Pain Society), Prof Helen Slater, Ms Marlene Eggert (on behalf of Leading Aged Services Australia), Ms Priyanka Rai (on behalf of Painaustralia), Prof Roger Goucke AM, and Dr Troye Wallett (on behalf of the Royal Australian College of General Practitioners). Thank you to the **expert panel** for their input reviewing the toolkit: Mrs Catherine Buckley, Ms Nicole Moore, Dr Paki Rizakis, Mr Peter Jenkin, Dr Raj Anand, Dr Sharon Andrews and Mr Steven Mantopoulos. Thank you also to the aged care providers that participated in the development and/or testing of the toolkit: Royal Freemasons Ltd, Coinda Village Inc., Southern Cross Care Living Ltd, United Protestant Association of NSW Limited and Bentley-Wood Pty Ltd. Finally, thank you to Tracy Hallen and the Australian Pain Society team and leadership, and the authors of *Pain in Residential Aged Care Facilities: Management Strategies 2nd Edition*, which this toolkit supports.

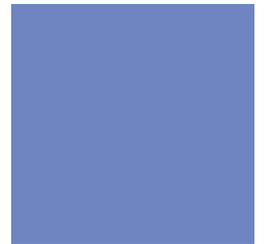
¹ Abdulla A, Adams N, Bone M, et al. Guidance on the management of pain in older people. Age Ageing. 2013; 42 Suppl 1:i1-57.

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Section A: Toolkit Overview



NAVIGATOR

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[Section D: Pain Management \(4 Steps\)](#)

[Four Steps to Pain Management Flowchart](#)

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Section A: Toolkit Overview

The PMG (Pain Management Guide) Toolkit 2nd Edition is a resource for aged care facilities to implement the book *Pain in Residential Aged Care Facilities: Management Strategies 2nd Edition*. For comprehensive information on specific aspects of pain management, refer to that book.

The toolkit is also for users to quickly find the answers they need or be directed where to look. [Printable Resources](#) are included, such as fact sheets, posters, flowcharts, assessment scales, plans, and checklists. These resources are online and can be printed and used in their unaltered state with attribution maintained.

Management staff at the facility and organisation level can use the toolkit for improving systems, procedures and education (refer to Section C: Systems, Governance and Education). Included are the Pain Action Plan for Residential Care and the Pain Management Audit Checklist for Residential Care. These tools help evaluate current pain management practice, identify areas that need improvement, and set pain management goals for the facility or provider. Management can refer to each section of the toolkit to guide organisational practice and policy, and can refer direct care staff to the toolkit accordingly. Management can use the Printable Resources included in the toolkit to encourage a pain vigilant and pain therapeutic culture, for example by displaying posters in facilities, or providing fact sheets to the relevant staff members or residents and family.

Direct care staff (such as care staff and nurses) can use the toolkit in a number of ways, depending on their role. They can read the reference book *Pain in Residential Aged Care Facilities: Management Strategies 2nd Edition* and the entire toolkit for broad education on pain management in aged care. Or they can use the toolkit as a quick reference guide. For example, a nurse wanting information about non-pharmacological options can refer to the relevant section and use the Printable Resources on that topic.

Implementing the PMG Toolkit 2nd Edition: Where to start?

Without reference to the Pain in RACF 2nd Ed book and significant resources and support, implementing every aspect of the toolkit is a challenge. However, the recommendations provided in the toolkit reflect current best-practice pain management. Adopting at least some of these recommendations will improve pain management at your aged care facility. For guidance on where to start, we suggest conducting a self-audit of your current pain management practice by using the [Pain Management Audit Checklist for Residential Care](#) (see page 25). This checklist will identify areas needing improvement. We also suggest using the [Pain Action Plan for Residential Care](#) to set overarching pain management objectives for your facility or across your organisation (see page 25).

Two case studies are interwoven throughout the toolkit, describing the management journey using the toolkit. The complete case studies are reproduced in full in the [online Printable Resources](#).

Introducing the case studies

Case study: Mario

Mario was born in Italy, and is one of five children. He met his wife, Francesca, and together they moved to Melbourne, Australia in their early 20s to begin a new life. Mario has two children, Sylvia and Marcus. Mario and Francesca loved cooking, growing vegetables in their garden, and feeding the visiting birds. Both Mario and Francesca can only speak some English, and often have their children translate when needed.

Mario was diagnosed with Parkinson's disease at age 78. He also had a diagnosis of Osteoarthritis. Francesca cared for Mario while his symptoms progressed until she was diagnosed with pancreatic cancer at aged 74 and died seven months later. Mario continued to live at home with support from Sylvia (Marcus lives interstate) and in-home care services for two years until he was admitted into the aged care facility at age 81. Sylvia and her children visit him regularly, and Marcus visits occasionally when he is in Victoria.

Case study: Margaret (Person Living with Dementia)

Margaret grew up in Townsville, Queensland with her three siblings. Margaret's father died from dementia at the age of 90. Margaret and her husband, Richard, have three sons. At age 85, Margaret was diagnosed with dementia. Margaret's cognitive abilities have rapidly declined, and at age 88 was admitted into an aged care facility. She can be communicative, but exhibits very poor recall. Prior to her admission, she had also been diagnosed with ovarian cancer and was receiving outpatient treatment at a hospital.

Margaret enjoys spending her days watching soap operas, listening to music from her youth, and talking to her children and grandchildren on the phone. Margaret has seven grandchildren and four great grandchildren. Although her memory problems cause her to occasionally forget who they are, Margaret lights up when she is able to speak with her family.

Brief summary of the sections of the toolkit

Section A: Toolkit Overview

How to use the PMG Toolkit 2nd Edition and how it is organised.

Section B: About Pain

Outlines key concepts about pain and its management.

Section C: Systems and Governance

Guides management staff on implementing the toolkit and best-practice pain management strategies for residential aged care systems and quality standards.

Section D: Pain Management

Details the 4 steps to pain management: identification, assessment, treatment, and monitoring/evaluation (see Flowchart on page iv).

Step 1: Pain Identification

Explains the ways the presence of pain can be identified to ensure that the residents' pain experiences are not missed.

Step 2: Pain Assessment

Explains how pain is assessed after it has been identified. Pain assessment aims to measure pain, understand the cause of it, and how the resident experiences pain and is impacted by it.

Step 3: Pain Treatment

Summarises how to manage and treat pain, and develop a pain management plan to incorporate the most appropriate methods of treatment for each resident. Non-pharmacological, pharmacological and complementary and integrative medicine (CIM) are explored.

Step 4: Monitoring and Evaluation

Discusses how to evaluate the effectiveness of pain treatment and continual monitoring of the residents' pain experiences.

The key messages in the toolkit are:

1

Person-centred care

- Pain is whatever a resident says it is, existing whenever or wherever they say it does.
- Person-centred pain management should be delivered by a multidisciplinary team. No matter how skilled, one person alone cannot provide whole of person-centred pain management.

3

A bio-psycho-social approach to pain

- Best practice pain management is bio-psycho-social. The biological, psychological and social dimensions of pain are considered, in addition to the context and environment in which pain is experienced.
- A single drug or treatment is often not effective for severe, long-lasting chronic pain. Multi-dimensional, long-term pain management plans are required.
- The goal of pain management isn't necessarily or exclusively to eliminate pain, but also to manage its medical, physical, psychological, and social impact on individuals' lives.
- Pain treatments range from psychological and educational approaches, movement and physical activity, complementary and integrative medicines, and pharmacological treatments.

2

Promote a pain-vigilant and pain-therapeutic culture

- Most people in residential aged care experience pain.
- Pain can be easily missed in aged care. Everyone in a facility (staff, residents, visiting family and friends) is responsible for identifying pain in a timely way.
- Promote a pain-vigilant culture at your facility, so that all staff are aware of the possibility of pain and are trained to spot it (Motto: SEE CHANGE, THINK PAIN).
- Promote a pain-therapeutic culture at your facility by proactively adopting multiple evidence-based best practises.

4

The 4 steps to pain management (identification, assessment, treatment and monitoring/evaluation)

- Follow the 4 steps to better pain management: pain identification, pain assessment, pain treatment, and monitoring/evaluation (see page iv).
- Ongoing pain assessment is important for optimal pain management.
- Pain identification, assessment, treatment, and monitoring/evaluation is a constant cycle.

Section B: About Pain



NAVIGATOR

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[Four Steps to Pain Management Flowchart](#)

[Printable Resources](#)

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Section B: About Pain

See this section for:

- A brief understanding about pain
- Bio-psycho-social model of pain
- Pain in special groups

Relevant Printable Resources

Fact Sheets:

For Aged Care Staff and Health Professionals

- [Fact Sheet 1 - Understanding Pain](#)

For Care Workers

- [Fact Sheet 1 - Pain and Older People in Residential Care Facilities](#)

For Residents and Families

- [Fact Sheet 1 - Pain Management in Residential Aged Care](#)

General Handouts:

- [Causes and Types of Pain](#)
- [Identifying Physical Pain Types](#)
- [How Pain May Affect a Resident](#)
- [Key Principles for Managing Pain in Older People](#)
- [Bio-psycho-social model of pain](#)
- [The International Classification of Functioning, Disability and Health \(ICF\) Model](#)
- [Pain prevention](#)

[Posters of essential pain management information](#)

Pain assessment scales and templates

- [Pain Care Goal Plan](#)

Key summary

- Pain is a distressing experience that is typically described by why there is pain, where the pain is and what type of pain it is.
- Pain can be acute or chronic/persistent.
- Manage pain using person-centred care approaches that consider bio-psycho-social factors.

Pain may not always be visible, but it is always real.

Most people in residential aged care facilities experience pain.

Understanding pain²

Pain is a distressing experience associated with actual or potential tissue damage that is influenced by our sensory, emotional, psychological, cognitive and social processes. It can be difficult to express the pain we feel in words.

Pain is typically described in three ways: the **why**, **where** and **what** of pain.

1. The reason **why** there is pain or the cause (such as tissue injury, a burn, a fall etc.),
2. **Where** the pain is or by its location (such as back pain), and
3. **What** type of pain it is (such as shooting pain or burning pain) and its frequency (such as how long it has lasted).

² Refer to Chapter 1 in *Pain in RACF 2nd Ed* for more detail about the nature of pain.

The why (the cause)

Pain can be described by the mechanism or the cause of the pain in which it is created by the body, such as nociceptive or neuropathic pain. A newer term being used is nociplastic pain.

Nociceptive pain <ul style="list-style-type: none">• Caused by tissue injury (e.g. a cut or sprain)• Usually is associated with some degree of inflammation• Most common type of pain• Often acute pain	Neuropathic pain <ul style="list-style-type: none">• Caused by nerve damage (a lesion or disease of the nervous system) e.g. in post shingles pain (post herpetic neuralgia) or diabetic neuropathy• Often chronic pain
Cancer pain can be nociceptive, neuropathic, or a combination of these.	

Nociplastic pain

Our understanding of how pain works is always evolving. A recently adopted term to describe some types of chronic pain is “nociplastic”. Nociplastic pain is caused by neurological dysfunction (nervous system sensitisation), but without evidence of nerve damage. A more familiar way to describe nociplastic pain may be ‘central sensitisation’ (when a person becomes more sensitive to pain). Examples of nociplastic pain include: fibromyalgia, tension headaches, complex regional pain syndrome (type 1), and some chronic lower back pain.

As the term “nociplastic” becomes more accepted, categorising pain into three types (nociceptive, neuropathic, nociplastic) will become widespread. As the term is not yet widely used in residential aged care, in the PMG Toolkit 2nd Edition, we refer only to nociceptive pain or neuropathic pain. However, when we discuss neuropathic pain, note that nociplastic mechanisms may instead be relevant.

The where (location)

The three most common sites of pain in older people are:

- The back
- Leg, knee or hip
- Other joints

The what (acute vs chronic)

Pain can be distinguished by what type of pain it is, such as acute or short-term pain, recurrent pain, and chronic long term or persistent pain.

Acute pain <ul style="list-style-type: none">• Short term and temporary• Stops at end of harmful event (disease recovery or healed injury)• Useful for determining issues in the body• Useful for informing treatment	Recurrent pain <ul style="list-style-type: none">• Acute pain that comes and goes e.g. rheumatoid arthritis or osteoarthritis, as the disease fluctuates	Chronic pain <ul style="list-style-type: none">• Injury has healed, but pain persists beyond the normal period of healing• Pain occurs most days for 3+ months• May not respond to pain medications• Serves no useful purpose
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Acute pain most often has a single and easily determined cause. Acute pain responds well to treatment that targets the disease or injury that caused the pain. A thorough examination is sometimes needed to assess the cause of acute pain if it is not immediately clear. Best treatment for acute pain includes staying active and simple pain medication is often helpful.

Chronic or persistent pain is more complex than acute pain and can be difficult to manage, especially for residents in aged care. Medication is often less beneficial for treating severe chronic pain, and the side-effects of long-term medications can outweigh the benefits.

What is the impact of chronic pain on a person?

Chronic pain is more than just feeling pain. It affects a resident's physical and mental wellbeing and reduces their quality of life. Chronic pain is associated with:

- Declining physical function, and less confidence in moving or exercise.
- Interference with activities of daily living, leading to less participation.
- Increased disability and deconditioning
- Loss of enjoyment and other mood disturbances, anxiety and depression
- Poor quality sleep
- Over-reliance on pain medications

Explore with the resident what impact the pain is having on all aspects of their life, as well as how are they coping, and the quality of the support they are getting.

The bio-psycho-social model

Pain is more than just a sensation or a symptom. Pain is an intensely personal experience. Like any experience, pain is influenced by our emotions,

thoughts, beliefs, relationships, and environment. The bio-psycho-social model looks at these influences to examine how chronic pain impacts a resident's life. We can also use this model to examine the impact of acute pain, though the treatment needs for acute pain are often not as comprehensive as those for chronic pain.

The bio-psycho-social model recognises that a resident's experience of their pain is more than just their medical diagnosis. Biological aspects (physical health, medical diagnoses, genetics), psychological aspects (the way we think, feel and do: such as mood, personality, behaviour) and social aspects (how we interact with others and the environment: such as family, relationships, culture, spirituality or religion) all have a role in the development, continuation and impact of pain (see *Figure 1* and [Printable Resources](#)).

The bio-psycho-social factors associated with each resident's experience of pain can represent both consequences of pain (e.g. "the pain makes me feel [an emotion] because I can't do [an activity] with [another person or people]") and things that can affect their experience of pain (e.g. a resident is embarrassed by not being able to do some of the physiotherapy exercises and refuses to engage with their physiotherapy treatment, which then might affect their biological recovery and their psychological wellbeing).

In other words, bio-psycho-social factors can both impact pain and be impacted by pain. Asking residents about how these areas of their lives are affected by pain improves our understanding of their experience and provides an opportunity to develop more relevant pain management plans. This means that treatments can target bio-psycho-social factors to improve a person's pain experience.

These three factors all interact with one another, and often all three aspects are intertwined in each person's experience of pain. For example, **psychological** treatments often involve working with the resident's family or carers (i.e. their **social** support system).

Advanced Topic: The International Classification of Functioning, Disability and Health (ICF)

Chronic pain is disabling. The World Health Organisation developed the ICF to conceptualise disability. The ICF is a bio-psycho-social person-centred model for how a person's disease, activity, participation, personal factors and the

environment all interact to affect their pain its impact.

The concepts of the ICF are relevant for pain management in aged care. We recommend using the ICF to understand how bio-psycho-social factors impact a person's pain experience, though some aged care staff may find it difficult to understand. See [Printable Resources](#).

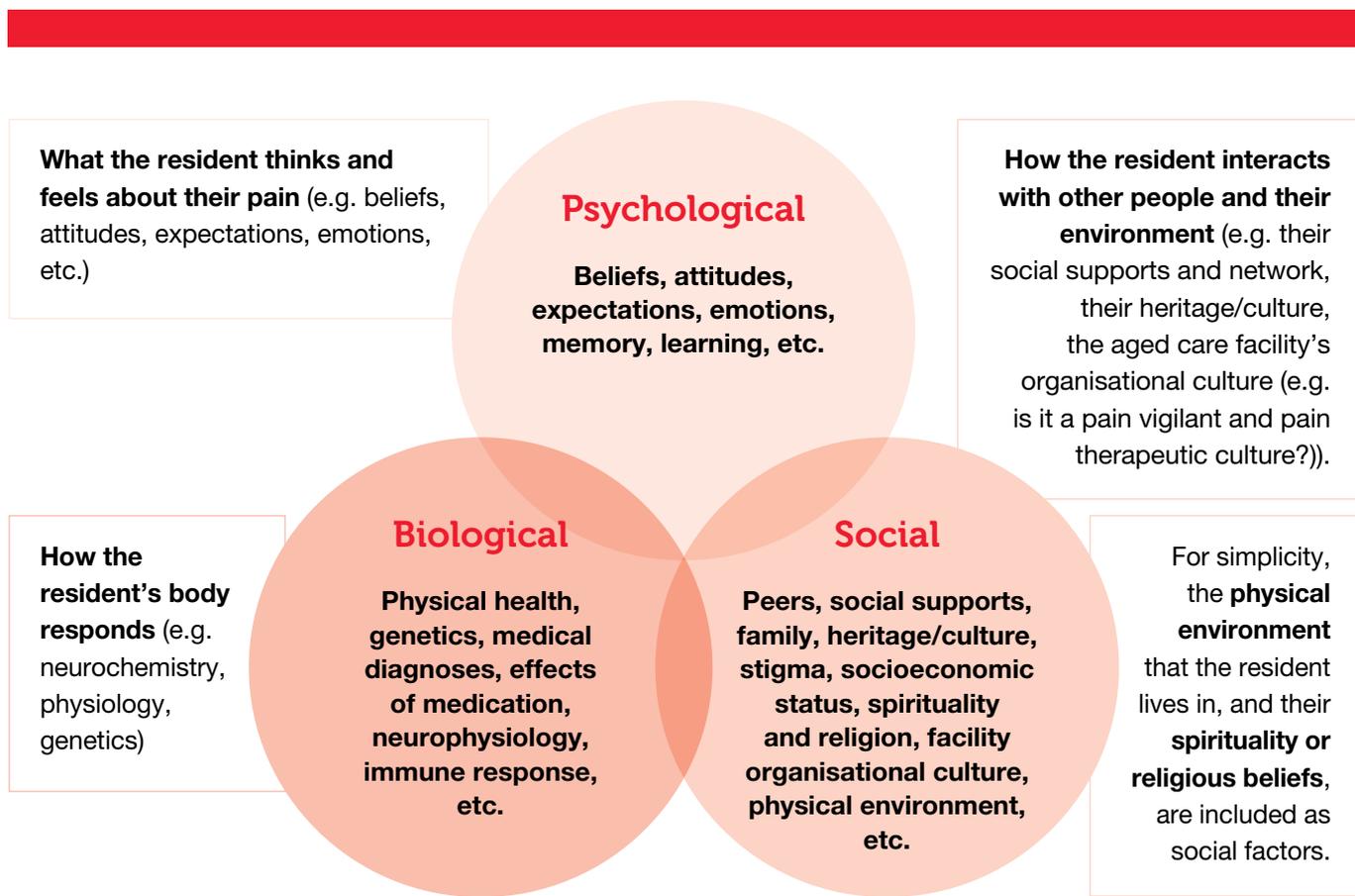


Figure 1: Bio-psycho-social model of pain. This model takes considers the biological, psychological and social aspects of a person's experience in order to fully understand the ways in which pain affects their life.³

The resident's physical environment

The environment is a social factor in the bio-psycho-social model of pain. This includes the space and place that the resident lives in. A resident's room makes a big difference to their safety and comfort. Ensure there is enough natural light in a resident's room. A view of natural landscape (e.g. they can see natural landscape outside of their window or have images of nature in their room) can improve mood (a psychological factor) and thus help alleviate the pain experience.

Spirituality and religion

If we think of spiritual or religious beliefs as a person's relationship with something 'bigger' or 'beyond' themselves, then spiritual or religious beliefs can be included in **social** factors. Though this poorly represents the breadth of spirituality, bio-psycho-social-spiritual pain models are currently underdeveloped.

Spirituality or religion may influence a resident's belief about the meaning of their pain, and how they cope with pain. Religion may be a source of positive mental health and strong social supports through religious groups; prayer or spiritual mindfulness may be beneficial non-pharmacological approaches when this is an important aspect of their life. Assessing the role of spirituality in a person's life can be important for pain management.

Example questions for the person include:

Is religion or spirituality important for you?
Are you part of a faith-based community?
Do you sometimes rely on your religion or spirituality when coping with pain?

See also: *ConnectTo* is a spiritual screening tool to support staff in the practice of spiritual care.

<https://meaningfulageing.org.au/product/connecto-spiritual-screening-tool-tool/>

³ Expanded from Figure 1 in Chapter 1 of *Pain in RACF 2nd Ed.*

PRACTICE TIP: Embedding the bio-psycho-social model of pain management at your facility

Acknowledge using the model: Some staff at your facility may already be using bio-psycho-social principles. However, most staff are probably unaware of this. Explicitly discuss with staff that the facility uses a bio-psycho-social approach to pain. Refer to the model or its principles in clinical notes and hand-over. Display posters in the staff room (see this Poster in [Printable Resources](#)). Pain champions can also help promote this message (see page 17 for [more on pain champions](#)).

Train staff and educate residents and families: Junior staff will need basic training on what the bio-psycho-social model is, and how and why it is relevant for pain (see this General Handout in [Printable Resources](#)). Residents and families may also need to be educated, especially residents who would be more familiar with the traditional biomedical model of disease (see this Fact Sheet in [Printable Resources](#)).

Build a strong multidisciplinary team: See page 16 for [establishing a pain multidisciplinary team](#).

Comprehensive pain assessment: Assess not only the severity, location and cause of pain, but also the psychological impact of pain, and the social effect that pain has on a resident's relationships with others. [See page 37 for more detail](#).

Goals of pain management: 100% pain relief is often not possible for chronic pain. But other goals such as improved function, re-engagement with hobbies, and social interaction with others are bio-psycho-social outcomes. See page 51 for [developing pain care goal plans](#).

Person-centred care: Bio-psycho-social principles overlap person-centred approaches to care. See page 15 for more on [person-centred care](#).

Pain in groups requiring special consideration

Being sensitive to the experiences and history of a resident promotes care that is most helpful for that person and their needs. Extra consideration is required for some groups who may experience, understand or express pain differently for various reasons. Some of these reasons may be due to different cultural or personal life experiences. This may include people from culturally and linguistically diverse (CALD) backgrounds or Aboriginal or Torres Strait Islanders. People who identify as lesbian, gay, bisexual, transgender or intersex may also require special consideration when managing pain. Different life experiences can also affect a person's experience of pain and its treatment,

such as having a disability, previously a care leaver (spent time in institutional care as a child), a veteran, or having experienced trauma or developed post-traumatic stress disorder for any reason⁴.

People in these special consideration groups are at greater risk of heightened pain sensitivity. Things that can contribute to the development of a pain-sensitive nervous system include: genetics, early childhood trauma, intense emotions, rumination, catastrophising, and fear of pain or harm that causes avoidance of activity. Being sensitive to individual circumstances and developing a comprehensive plan is important in managing both the psychological and physical experiences of pain.

⁴ Refer to Appendix 4 of *Pain in RACF 2nd Ed* for resources that are available for residents who may require special consideration (CALD, Aboriginal and Torres Strait Islander, LGBTQIA+).

Section C: Systems, Governance and Education



NAVIGATOR

[Section A: Toolkit Overview](#)

[Section B: About Pain](#)

[Section C: Systems and Governance](#)

[Section D: Pain Management \(4 Steps\)](#)

[Four Steps to Pain Management Flowchart](#)

[Printable Resources](#)

or continue reading through this Section



Section C: Systems, Governance and Education

See this section for:

- Pain vigilant and pain therapeutic cultures
- Importance of a multidisciplinary team for pain management
- Pain education and training for aged care staff
- Documenting quality indicators and conducting audits

Key summary

- Pain management can be improved with good systems, governance, and education.
- Establish a **pain vigilant** and a **pain therapeutic** culture to support better pain management. **Person-centered care** is also integral for providing best quality care.
- *Pain is everyone's business: a multidisciplinary pain team* (pain MDT) includes anyone with a key role in identifying, assessing, treating and monitoring pain.
- Document pain management practices for quality assurance and assess performance against the Aged Care Standards.

Overview of systems, governance and education⁵

Comprehensive information systems, well-developed care delivery systems and robust monitoring systems are essential for pain management in aged care. Key points include:

1. Good systems and governance translates to better pain management
2. Good governance facilitates or enables:
 - Safe and good quality clinical care that uses evidence-based pain management
 - Continuous improvement of clinical service

- A way to review, measure or collect data and evaluate your systems
- Documentation as evidence of quality assurance

Relevant Printable Resources



Fact sheets for residents and families:

- [Fact Sheet 1 - Pain Management in Residential Aged Care](#)
- [Fact Sheet 2 - Opioid Medications](#)

Fact sheets for aged care staff and health professionals

- [Fact Sheet 1 - Understanding Pain](#)
- [Fact Sheet 2 - Pain Identification](#)
- [Fact Sheet 3 - Pain Assessment](#)
- [Fact Sheet 4 - Non-Pharmacological Pain Management Strategies](#)
- [Fact Sheet 5 - Pharmacological Pain Management Strategies](#)

Fact sheets for care workers

- [Fact Sheet 1 - Pain and Older People in Residential Care Facilities](#)
- [Fact Sheet 2 - Assessing Pain](#)
- [Fact Sheet 3 - Pain Management without Medicine](#)
- [Fact Sheet 4 - Pain Management with Medicine](#)
- [Fact Sheet 5 - Tips for reassuring residents about their pain](#)

[Posters of essential pain management information](#)

[Pain Care Goal Plan](#)

[Pain Management Audit Checklist for Residential Care](#)

[Pain Action Plan for Residential Care](#)

⁵ Refer to Chapter 10 of *Pain in RACF 2nd Ed* for a detailed discussion about systems, governance and education.

The following structures are needed for best-practice pain management:

- A** **A pain vigilant and pain therapeutic culture**
Promoting a workplace pain culture
- B** **A strong multidisciplinary pain team (pain MDT)**
- C** **Pain education and training for staff**
Staff trained in pain. Education for residents and families
- D** **A bio-psycho-social approach to pain management**
See page 9
- E** **Embedding 4 steps to pain management into practice**
Pain identification, pain assessment, pain treatment, and evaluation/monitoring. See Section D: Pain Management

Figure 2: Good systems enable or promote the conditions for good pain management.

The following governance processes are also recommended:

- F** **Quality indicators** to measure important aspects of pain management)
- G** **Pain Management Audit Checklist for Residential Care** to evaluate your pain management systems
- H** **Pain Action Plan for Residential Care** for providers to identify their pain management strengths and potential areas to excel in

Figure 3: The following governance processes are recommended.

Structures A, B, and C are expanded upon in the text below.

For more on Structure D, see page 9.

For more on Structure E, see Section D (page 26).

Structures F, G, and H are also expanded upon later in this Section (page 25).

A **A pain vigilant and pain therapeutic culture: Promoting a workplace culture for pain**

Establishing a workplace culture that supports better pain management is challenging. Ideally, a senior nurse or nurse practitioner oversees pain management at the facility or across the entire organisation. Appointing a pain champion also fosters a culture and focused on pain.

The organisational culture of the facility directly affects each resident's experience of pain because it has a strong influence on the environment in which they live. Promoting a strong and healthy workplace culture can support staff and resident wellbeing in addition to improving pain management practices.

RACFs should strive to promote *pain vigilant* and *pain therapeutic* cultures. A **pain vigilant culture** is one where every person in a facility is constantly mindful of pain and works as a team to identify pain in a timely way (see page 28 for more detail). As residents with dementia or other considerations affecting communication may be unable to articulate their pain experience, staff need to be vigilant for pain. Policies should reflect this extra vigilance.

A **pain therapeutic culture** ensures that effective preventative and proactive strategies are embedded in the everyday routines of the facility and is invested in managing residents' pain as part of the daily care routine, supported by policies and procedures that reflect a nurturing and respectful environment that provides the most appropriate, evidence-based care for each individual (see page 47 for more detail). A positive and supportive culture is needed. Improving the morale at the facility will benefit the quality of life of the staff and residents. Developing trusting relationships aids pain treatment programs.

The elements that establish a pain vigilant culture are discussed in Section C: Pain Management (see Step 1 on pain identification, Step 2 on pain assessment, and Step 4 on monitoring and evaluation). Step 3 (pain treatment) lists the elements for building a pain therapeutic culture. A central element for building a pain therapeutic culture and to care service is delivering **person-centred care**.

Person-centred care

Pain management strategies need to be relevant to the resident and their families to be effective. Person-centred care does this by placing the resident, as an individual, at the forefront and by tailoring all care and treatment to their specific needs and preferences. Person-centred care is important in all aspects of care and communication with residents. Staff should take interest in the resident's life, experiences, and relationships, for example. This conveys to residents that they matter to the staff, who are listening to them and enabling open communication about their care and treatment.

Understanding what each person likes and dislikes as well as their personal history can help staff design activities and treatment programs that residents will enjoy. Less structured programs that are easier to follow and continue will often be more beneficial than programs that are more difficult for residents to maintain. Engage with family to help encourage residents to continue following their programs.

Adapt planned activities and treatment programs for each resident by considering their physical and cognitive abilities and their limitations to engage with treatments. For example, physical activity programs may need to be adapted by considering the complexity of the program and whether supervision is needed.

Additionally, managing pain for people with dementia requires determining their capacity. Person-centred care considers the individual rather than the diagnosis. People

with dementia will have different levels of understanding and capacity; therefore, a 'one-size-fits-all' approach is not appropriate based only on their dementia diagnosis. People living with dementia may still be able to make meaningful decisions about what happens to them. Avoid deferring to family unless the resident demonstrates they are incapable of deciding themselves.

Anyone making decisions on behalf of a resident must make decisions that reflect the wishes of the resident rather than their own preferences. Staff can practice **supported decision making** to enable all residents to be involved in decisions that affect their care. More information can be found about supported decision making through the following link:

<https://cdpc.sydney.edu.au/research/planning-decision-making-and-risk/supported-decision-making/>

Workforce or Organisational Culture

Organisational culture is a facility's 'sense-of-self', its underlying values, and observable patterns of behaviour (i.e. what the facility repeatedly does). This type of culture is different from ethnic or cultural values that relate to where in the world a person or their family grew up. A facility's culture is strongly influenced by the aged care provider head office, and management and senior staff at the facility, standard practice in sector, and regulation. Other influences on the culture of a facility include staff morale and the general values and attitudes of the surrounding community. Subcultures may also exist, such as how staff in particular positions (e.g. care staff, non-clinical support staff, lifestyle staff, etc.) see themselves in their roles.

In general, aged care organisations should promote a positive, respectful, empowering culture. Specific to pain management, facilities should strive for a pain vigilant and pain therapeutic culture.

B

A strong multidisciplinary pain team (MDT)

A person-centred model of care is best achieved by establishing a multidisciplinary pain team (MDT) at each RACF. This means building a team of people with expertise across different areas relevant to pain management. No matter how skilled, one person alone cannot provide the necessary integrative person-centred care for managing pain.

Gold standard care in gerontology in general as well as in pain management is provided by a MDT. For residents with pain, a comprehensive pain management plan should be developed by combining advice from all team members and involving the resident and their family. Communication about pain management should occur amongst the team, with other relevant staff, and the resident and their family.

To foster a pain vigilant and pain therapeutic culture in aged care facilities, all staff must be involved with the identification, assessment, management, and monitoring of pain. The pain care team can promote best practice pain management by following a clear and consistent protocol for the pain management of each resident. It is also necessary to outline clear expectations for the roles and responsibilities of all staff.

Person-centred pain management should be delivered by a multidisciplinary pain team. No matter how skilled, one person alone cannot provide every aspect of care included in a person-centred pain management plan

The MDT can also discuss training for staff and identify which elements of pain management training need priority. Some informal training may also assist individual staff caring for specific residents. Individual training may include teaching strategies that have been found to be helpful for caring for specific residents, often refined through trial and error.

Figure 4 illustrates some key roles in the team.⁶ See below for a summary of these roles.

Developing a multidisciplinary pain team (MDT). Where to start?

Pain is one of many competing clinical concerns in residential aged care. But a MDT at the facility will: optimise decision making, enhance pain management, improve overall clinical outcomes, and strengthen teamwork and inter-disciplinary relationships.

The aim of the MDT is to make recommendations about the residents' personalised pain management plans. These decisions are based on discussion and consensus amongst the team.

The following elements are needed for a MDT:

- **Leadership: A senior nurse, doctor or allied health clinician, can lead the team.**
- **Formalised: Organisational support is needed from senior management.**
- **Diversity: At least 3 different disciplines should attend each meeting**
- **Routine: Meet regularly (e.g. fortnightly). Set a time and location in advance.**
- **Sharing knowledge: Findings from the team need to be communicated to other staff, residents and families.**

To build a MDT, we suggest starting with a core group of team members. This will vary from facility to facility. Once a core team has been established, consider expanding the team to other staff roles.

If a facility does not have the appropriate in-house expertise to build a MDT, external organisations (if available) can provide the training and support so that facility staff can manage an ongoing multidisciplinary pain management program. Facilities should refer to a pain specialist, geriatrician or multidisciplinary pain service if troublesome pain persists after reasonable trials of treatment options.

For a practical example on how to build a MDT, refer to '[A multidisciplinary team pain management model for residential aged care](#)' by HammondCare.

⁶ See Figure 6 in Chapter 10 of *Pain in RACF 2nd Ed* for more information about recommended organisation and staff responsibilities and relationships.

Facility Management

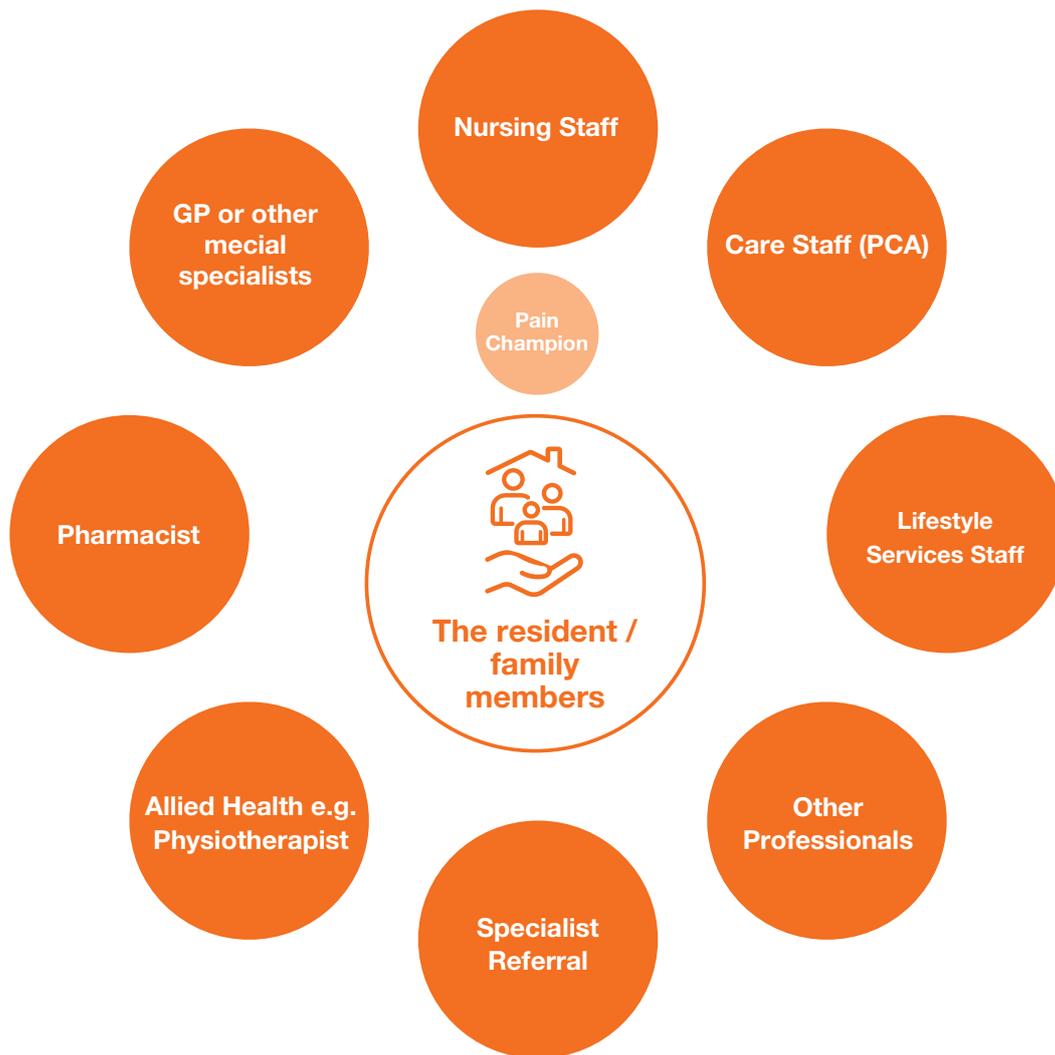


Figure 4: Key roles in the pain care team. The resident and their family or representative are at the centre of the pain care team. All staff play a vital role in best practice pain management.

PRACTICE TIP: Pain Champions

A pain champion is a staff member interested and motivated to improve pain management at the facility. A pain champion could be any direct care staff member with suitable experience, knowledge and skills. Preferably, the pain champion should be a health professional (e.g. a Registered Nurse) with current knowledge about the pain management process.

The role of a pain champion should include:

- Encourage a pain vigilant and pain therapeutic culture
- Access to ongoing training and education
- Support ongoing pain management training and education for all care staff

- Distribute resources to staff, residents and families (e.g. fact sheets on pain management)
- Participate in pain management quality improvement activities
- Facilitate collaboration between the multi-disciplinary team in pain management
- Assist in referral of residents to pain specialists when necessary

Skills and competencies that a pain champion should have:

- Able to communicate and collaborate effectively with staff, residents and family
- Organisational skills, ability to plan and problem solve

Residents/family members

Residents and their families should be involved in all aspects of pain management, including the planning, implementation and evaluation of care. This is person-centred care. Family involvement often requires educating them about pain and discussing how they can support the resident and their treatment plan (use the PRAISED principle, see practice tip to the right). Fears about pain and its treatment may be calmed for the resident and their family when they are included and understand the decision-making process of developing a pain management plan.

For residents living with dementia, closely coordinating with their families is beneficial. Families can help provide context to behaviours that may indicate pain and help interpret the meaning of these behaviours. They can also provide regular feedback on the resident's function and wellbeing.

Family can have a significant role in supporting the resident with pain identification and treatment, and are a valuable (informal) member of the pain management team. Families can encourage the resident to participate in new treatments, and adhere to existing treatments. Families may themselves need recognition, support and education in how they add value to the team.

Psychological impact on the family

A resident's pain may also affect their support networks such as their family. Pain is distressing for families as they share the resident's suffering and diminished quality of life. They also may experience their own stress and anxiety. When discussing a resident's pain with family:

- Ask if and how they are affected by the resident's pain
- Ask in a respectful and sensitive way
- Involve them in discussions

PRACTICE TIP: The PRAISED principle - Discussing the resident's pain with the family

Families may feel overwhelmed or powerless when a resident has persistent pain. We suggest the following principles when talking with families:

Proactive: Staff should be proactive in contacting families and providing information about pain management, and proactive in educating families about pain. Use the fact sheets provided.

Respectful: Building a trusting relationship with families is important in pain management.

Available: Staff need to be available to discuss any family concerns about pain management.

Involve: Staff should actively involve the family in supporting the resident and their pain management plans.

Sensitive: Staff should be sensitive to the needs of the family as they may also be suffering from the consequences of the resident's pain and its impact.

Educate: Wherever possible, educate the family on pain.

Direction: Families may feel lost in how to help a resident with pain. Staff providing direction or suggestions may be helpful.

Care staff (i.e. personal care assistants, PCAs)

Different aged care providers may use other names for this role. PCAs are also referred to as Personal Care Workers (PCWs) or Personal Support Workers (PSWs).

PCAs are in a valuable and unique position because their tasks include substantial interaction and regular physical contact with the residents. PCAs are most likely to notice day-to-day changes in residents, and have an important role in identifying behaviours or other signs that may indicate pain. Showering, dressing, grooming, mobility, eating and toileting can all trigger or expose underlying pain, and PCAs need to be actively observing for pain indicators ('red flags') when assisting with personal

care. This is vital for people with dementia or those who cannot communicate with others about their pain. PCAs should receive basic training in observing and recognising pain indicators in people with dementia.

PCAs may have established a level of trust with residents. Some residents may feel more comfortable expressing minor aches and pains informally with PCAs than with other professionals such as nurses or GPs. PCAs are also involved with pain management in various ways beyond pain identification, such as repositioning residents or providing comfort.

PCAs are well placed to assist with pain management so that clinical staff workload is reduced, provided they receive appropriate training and recognition. While additional responsibilities for PCAs will vary between RACFs, such as basic pain charting or using simple pain assessment scales, they can also help promote educational messages, help residents practice new skills and maintain health.

Lifestyle services staff

The role of leisure and lifestyle staff in pain management is often underappreciated. They plan activities that support the social, physical, emotional, intellectual, cultural and spiritual needs of the residents. Lifestyle staff have direct contact with residents on a regular basis, and have often established a level of trust with residents and families. They are well-placed to identify any signs of pain during activities, or residents may express pain or discomfort to lifestyle staff during activities where they are concerned about being seen as a bother to clinical or care staff).

Lifestyle staff can help support residents and the pain care team in developing a routine conducive to pain management, incorporating pain management strategies in daily life, and encouraging resident participation in activity-based pain management and treatment. Though rarely framed as such, creative and meaningful leisure activities (such as craft, music, dance, art, gardening, etc.) are also an important pain treatment approach. For residents with pain,

these diversional activities should be considered activities of clinical benefit. These activities help residents cope with pain by helping them adapt, create meaningful goals, and distract from pain.⁷

Residents often experience multiple losses when admitted to an aged care facility (loss of independence, loss of previous community engagement, loss of established structured living, loss of the family home, etc.), and this may result in a loss of sense of self and sense of purpose, which may impact on their pain experience. Lifestyle staff may be instrumental in providing the means and resources so that residents can rebuild a sense of purpose. Lifestyle staff can also promote social activity and help residents rebuild social networks. With other staff, family and residents, lifestyle services also support residents in adhering to non-pharmacological pain management treatment programs, whether formal and structured or not.

GP or other medical specialists

The resident's medical practitioner or general practitioner (GP) relies upon an accurate assessment and reporting from nursing and care staff, particularly for people unable to recall and report pain when the GP visits. The GP, as a member of the multidisciplinary team, brings the medical perspective to each case, and considers optimal care, weighing the risks against benefits as informed by the care team as well as the resident (according to their capacity) and their family or representative. The GP prescribes medications when appropriate and reviews residents for the need for further investigations and/or referral to a pain management or aged care specialist for complex pain problems.⁸

Nursing staff

Registered nurses (RNs) in RACF settings usually coordinate clinical care in collaboration with the resident (or their representative) and the GP. This includes planning and implementation of medication administration, wound and other complex nursing care. Targeted physical examination, pain history, current presentation, non-pharmacological treatments and response

⁷ Refer to Chapter 3 in *Pain in RACF 2nd Ed* for more information about creative activities for pain.

⁸ For further information on the role of the GP in a multidisciplinary team, see <https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/silver-book/silver-book-part-b/collaboration-and-multidisciplinary-team-based-care>

to pain medication should be assessed and documented, with critical findings communicated to the GP. RNs are a point of contact for the resident and their family members or representatives. They direct enrolled nurses (ENs) and PCAs to perform delegated tasks as needed. A nurse practitioner (NP) is authorised to prescribe medications as well as develop and implement treatment plans. NPs employed by providers can also provide pain management training for staff and review the practices and policies of the facility.

Allied health

This includes physiotherapists, osteopaths, occupational therapists, podiatrists, psychologists, speech pathologists, dieticians etc. Broadly, allied health professionals help identify and assess issues to then develop a treatment or management plan that addresses those issues and aligns with the goals of the resident. A common example in aged care is a physiotherapist who can conduct specific pain assessments and then develop a treatment plan that may include exercises to alleviate and prevent pain.

- **Clinical psychologists** can identify and help residents who might benefit from learning or re-exploring skills to manage their pain, support and treat residents with emotional difficulties associated with chronic pain, and they can also provide psychological support to staff. Professional support for staff is important because fatigued or staff burnout may lead to de-personalised care, which is when staff provide the same care to all residents, regardless of their individual needs (i.e. the opposite of person-centred care), and therefore diminish the quality of care received by residents.
- **Physiotherapists** can support the resident to improve their physical activity levels, and also encourage their family and the staff to help the resident maintain or increase their physical activity and exercise. Staff in this role can develop enjoyable programs that cater to all residents and their individual needs rather than running a one-size-fits-all exercise group. Therefore, physiotherapists can offer a range of physical activity programs that suit the different needs and interests of the residents by adjusting programs to be suitable for residents with physical or cognitive impairments.

Other professionals

Other professionals such as **social workers, counsellors, and pastoral care** all have a role by providing support to residents in a more general way that intersects with pain management. For example, these professions may be involved during palliative care by providing support and improving the practical and emotional needs of the resident.

Pharmacists

Support from a pharmacy is generally available for aged care facilities. Pharmacists should be available to conduct regular reviews of any complex medication regimens and to comment on the mode, timing and ideal combination for medication administration. For residents at the end of life, time is critical and medications may need to be started and adjusted quickly. Therefore, pharmacists can provide expertise: on anticipatory prescribing practices, emergency stock, to provide end of life medications in a timely and safe manner including advice on alternative routes for administration.

Facility management

Management are responsible for enacting policies and procedures that enable a nurturing, positive, respectful facility for both residents and staff. It is important for residents to be comfortable where they live, and for staff to be satisfied with their work. Management should endeavour to develop a work environment that is mindful of the psychological wellbeing of staff, and be aware of potential compassion fatigue and staff burnout. Management must ensure that staff are well-educated and trained in evidence-based pain management. Management are responsible for fostering a pain vigilant and pain therapeutic culture at the facility. Management oversee the development and maintenance of appropriate systems, driving continuous improvement in clinical care, and governance that is conducive to best practice pain management. Management are also responsible for structuring night staff routine and conditions that promote residents not being unduly disturbed.

Specialist referral beyond the provider

For more severe or chronic forms of pain or if troublesome pain persists after exhausting usual treatment options, consider further specialist referral. This may not be practical in some cases.

Specialists to consider approaching for additional support include pain specialists in medical or allied health, geriatricians, or multidisciplinary specialist pain clinics. Palliative services are also important, and resident issues should be referred to them early. Pain is one of the most common symptoms in palliative care, and a palliative care approach that is holistic and team-based can help address the practical, emotional, social and spiritual needs of the residents and their families. This philosophy synergises with the bio-psycho-social approach to pain management.

C

Pain education and training for staff

Staff need to be educated and trained in pain management. Staff confidence and overall pain management standards are improved when staff receive education to better understand pain, address pain identification, assessment and management. A systematic education program for staff at all levels is an important component of any initiative to enhance pain management in aged care.

General points for pain education and training

- All staff members in direct contact with residents should have pain management training.
- Every shift needs a staff member available who is trained in pain management.
- Education sessions should be conducted regularly and reinforce the key messages of pain management strategies and current best-practice.
- Training can be provided by a nurse practitioner or clinical nurse trained in pain management.

(See page 22 for more on pain education.)

Educating residents and families is a major part of pain management. Refer to page 18 for more on how families can help.

(See page 22 for more on pain education.)

These fact sheets can provide information and educate staff, clinicians and residents and families about pain.

For residents and families:

- [Fact Sheet 1 - Pain Management in Residential Aged Care](#)
- [Fact Sheet 2 - Opioid Medications](#)

[Fact sheet for visiting general practitioners \(GPs\)](#)

For aged care staff & health professionals:

- [Fact Sheet 1 - Understanding Pain](#)
- [Fact Sheet 2 - Pain Identification](#)
- [Fact Sheet 3 - Pain Assessment](#)
- [Fact Sheet 4 - Non-Pharmacological Pain Management Strategies](#)
- [Fact Sheet 5 - Pharmacological Pain Management Strategies](#)

For care workers:

- [Fact Sheet 1 - Pain and Older People in Residential Care Facilities](#)
- [Fact Sheet 2 - Assessing Pain](#)
- [Fact Sheet 3 - Pain Management without Medicine](#)
- [Fact Sheet 4 - Pain Management with Medicine](#)
- [Fact Sheet 5 - Tips for reassuring residents about their pain](#)

[Posters of essential pain management information](#)

D

A bio-psycho-social approach to pain management

See [Section B](#) (page 9) for information about the bio-psycho-social model. See also [Printable Resources](#).

E

Embedding 4 steps to pain management into practice

See page iv for the [4 Steps to pain management](#). See also [Section D](#) (page 26) for more on [pain identification](#) (page 27), [assessment](#) (page 37), [treatment](#) (page 46) and [monitoring/evaluation](#) (page 69).

More on pain education

Key staff should have regular education in pain management, either for training or as a refresher.⁹ Short ‘in-house’ education sessions could include the following topics:

For all staff

- *Overview of pain in aged care: Acute vs chronic pain, pain in older people, pain myths and misconceptions and techniques on how to dispel them.*
 - *Introductory session on resources available:* e.g. Pain in RACF 2nd Edition and PMG Toolkit 2nd Edition, including Printable Resources
 - *Bio-psycho-social model of pain:* All aged care staff should be aware of the bio-psycho-social model as well as the red flags for pain in people living with dementia (page 34). Some aged care staff are likely to be unfamiliar with the concept of the bio-psycho-social model, or may underestimate the importance of treatment beyond medications. Ensure that all staff are aware of the bio-psycho-social model and their role within it.
 - *Pain identification:* pain vigilance and ‘red flags’. Training staff to recognise behaviours that indicate pain helps promote a pain vigilant culture, and regular training helps staff maintain pain vigilance.
 - *Pain assessment:* self-report scales and observational pain scales. Senior staff should be well-trained in using observational pain scales (such as the Abbey Pain Scale¹⁰), and can then supervise other staff in their use. Care workers and non-clinical staff (e.g. lifestyle services) should receive basic training in observing and recognising symptoms of pain in people with dementia and to take note of any deviations in residents’ routines or behaviours; these changes may indicate pain and should be reported to a nurse for further investigation.
- *Non-pharmacological approaches to pain:* Staff need to be aware of, and skilled in, the provision of non-pharmacological treatment options for pain. Care staff should also receive regular training in how to move residents who have contractures because incorrect manual handling may worsen pain.¹¹
 - *Recognition, assessment and treatment of pain for people living with dementia.*¹²

For nurses and medication staff

- *Pharmacological approaches to pain:* It is recommended that a nurse practitioner (or senior nurse) oversee medication management training for nursing staff.
- *Pain care planning and escalating pain control:* Staff also need to be trained in the pathways that can be taken to escalate pain control (either at a facility, provider or external level).

For night staff

- As residents may display different patterns of behaviour at night, focused training on the relationship between sleep and pain, de-prescribing, and the relationship between behavioural and psychological symptoms of dementia (BPSD) and pain. It is also important to train night staff to conduct assessments to determine if pain is causing problems with sleep for residents who are restless at night. Education on strategies that support residents who wake at night and have persistent pain¹³ would be of benefit, as well as non-pharmacological strategies to assist residents who display BPSD that may be in response to pain.

⁹ See Australian Pain Society short training course - Management in Aged Care - Training Programme

¹⁰ See Appendix 5: Abbey Pain Scale and Appendix 6: Pain Assessment IN Advanced Dementia Scale from *Pain in RACF 2nd Ed* for examples of observational pain scales.

¹¹ See Table 14 in Chapter 4 of *Pain in RACF 2nd Ed* for information on manual handling.

¹² See Dementia Training Australia for a free online dementia course on this subject. <https://dta.com.au/online-courses/the-pain-puzzle/>

¹³ See page 63 of this PMG Toolkit and the [Printable Resources](#) for more information about sleep and pain.

Organisational systems, governance and quality

Policies that support residents' rights to quality pain management need to be reflected in practice and evidenced in clinical documentation and work protocols.

The Aged Care Act (1997) stipulates that all residents should be “as free as possible from pain”. Of the eight Aged Care Quality Standards with which all aged care services must comply (see Figure 5), **Standard 3** regarding personal and clinical care is most relevant for pain management.

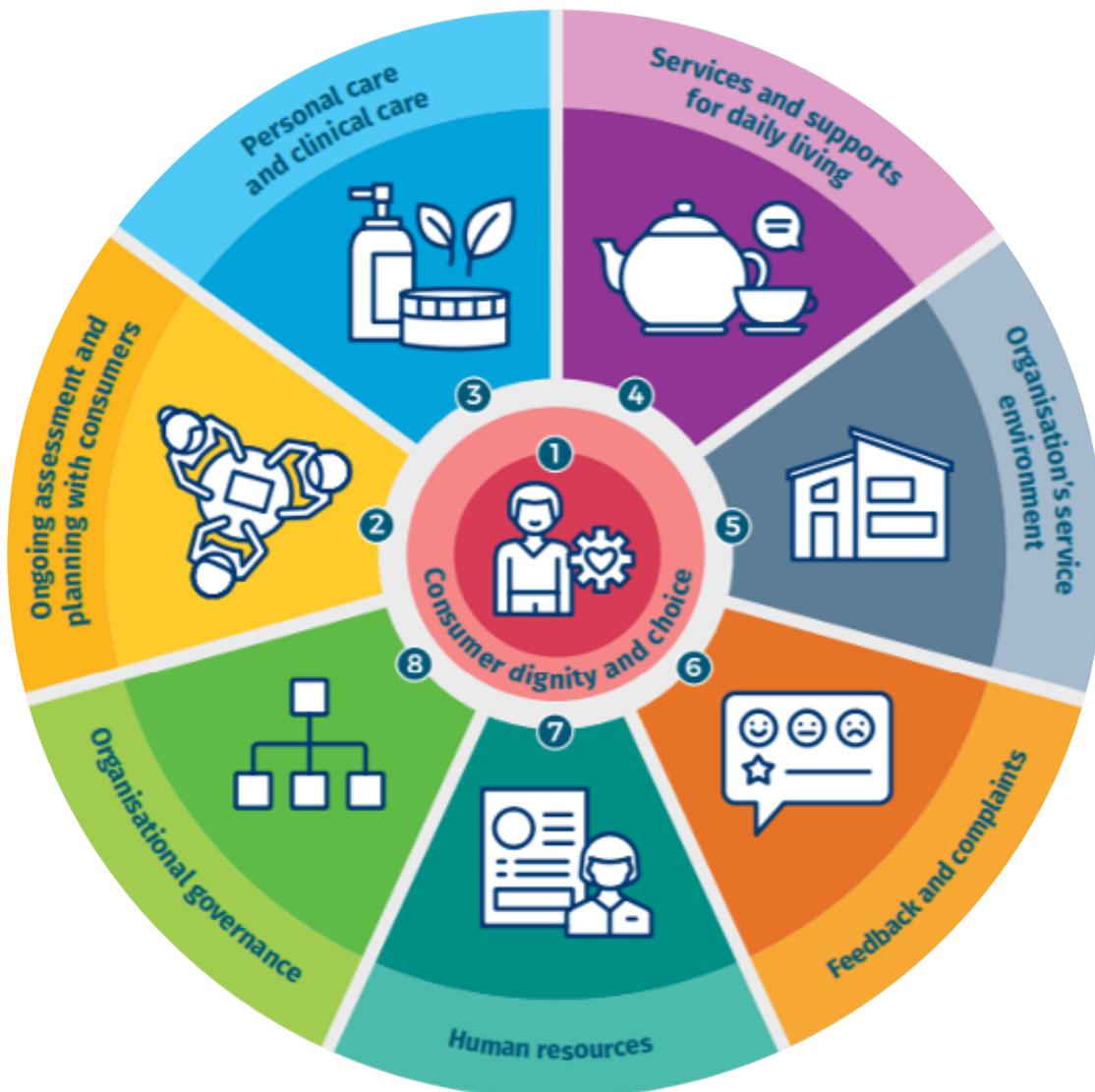


Figure 5: The eight Aged Care Quality Standards. Image credit: © Aged Care Quality and Safety Commission 2018, Guidance and Resources for Providers to support the Aged Care Quality Standards.

Requirement 3 (b) of **Standard 3** requires “the effective management of high-impact or high-prevalence risks associated with the care of each consumer”. The intent of this requirement is that aged care facilities do all they can to manage these types of risks. As persistent pain in residential aged care is both highly prevalent and has a substantial impact on health and wellbeing, facilities need to demonstrate they use evidence-based best-practice pain management.

Requirement 3 (c) of **Standard 3** requires “the needs, goals and preferences of consumers nearing end of life are recognised and addressed, their comfort maximised and their dignity preserved”. The intent of this requirement focuses on clinical care delivery at the end of each resident’s life. Unless the resident has indicated a goal or preference otherwise, always assume that to be “as free from pain as possible” is a goal in end of life care.

A number of other standards also link to **Standard 3**, such as **Standard 1** (consumer dignity and choice), **Standard 2** (ongoing assessment and planning with consumers), **Standard 7** (sufficiently skilled and qualified workforce) and **Standard 8** (clinical governance framework standard).

Applying all these standards to pain management promotes a facility driven by quality and innovation, with well-informed residents (and their families or representatives) enabled to exercise dignity and choice, and who are supported by a pain-educated and upskilled aged care workforce.

Care Plans and Advanced Care Plans

Ensure the following are included in each resident's care plan:

- Pain Care Goal Plan (see page 51).
Effective pain management involves an agreed upon and shared understanding between the resident and staff. The goal of treatment is often **not** '100% no pain', but rather 'less pain and distress' with an increase in function. Goals such as this are important for medication management; a goal of 'no pain' can lead to escalating prescribing and polypharmacy, with detrimental consequences. Identifying what elements of the pain experience have the greatest impact on the person with dementia can also be challenging, especially as cognition worsens. Discussions with family and staff with daily contact may be needed to decide on any goals of treatment.
- All sleep requirements.
- Physical activity program.
- Tailored protocols or strategies for manual handling that have been found to be helpful in manual transferring the resident.
- Complementary and integrative medicine (CIM) approaches should be documented and administered with an open mind to each resident's personal preferences and

their cultural and spiritual background.

- For residents living with dementia, the care plan should reflect whether to use a formal observation assessment scale or not (or that using a self-report scale still appropriate).
- For residents living with severe dementia, ensure the person is still undertaking relaxing activities, socialisation where able and monitoring of oral intake and other needs.
- As dementia advances, it may be necessary to formally schedule basic pain management treatments such as sufficient rest for the resident, sufficient physical activity, and addressing comfort needs. The family's role may also need to be more closely coordinated with staff.

Advance care planning (ACP) can ensure the resident's preferences for predictable events are met, especially at the end of life. Offering ACP early is important for residents living with dementia.

Documentation as evidence of quality assurance and quality indicators

Aged care services must be able to provide evidence of compliance with and performance against the Aged Care Standards. Therefore, an audit trail for pain management policies should be evident. Three additional tools are recommended to support evaluating a facility's quality assurance, assess compliance with meeting the quality standards, or evaluate a facility's pain management strengths and identify areas to excel in. These three tools are:

- Quality indicators for pain management¹⁴
- Pain Management Audit Checklist for Residential Care (see [Printable Resources](#))
- Pain Action Plan for Residential Care (see [Printable Resources](#))

See below for more detailed descriptions of these tools.

¹⁴ See Printable Resources from *Pain in RACF 2nd Ed* for information on quality indicators

F

Quality indicators for pain management

Objective and quantifiable clinical indicators based on best available evidence can guide clinical practice and optimise the quality management process in pain management. Use quality indicators to help assess and evaluate a facility's systems and governance, identify gaps in care practice, and acknowledge organisational strengths. There are no quality indicators for pain prescribed in the *Aged Care Act* or the *Aged Care Quality Standards*, except a broad statement that residents should be as free as possible from pain, criteria to demonstrate that this outcome has been met, and standards that support good clinical care in general. We recommend the following six quality indicators for evaluating whether a facility is meeting the quality standards¹⁵. More detail on quality indicators for pain are included in the [Printable Resources](#) of *Pain in RACF 2nd Ed.*

Recommended quality indicators for pain management in residential aged care facilities:

1. Screening for pain on admission
2. Regular screening and treatment for pain
3. History and physical examination for pain
4. Addressing risks of nonsteroidal anti-inflammatory drugs (NSAIDs)
5. Preventing constipation in patients using opioid analgesia
6. Reassessment and documentation of pain intervention

G

Pain Management Audit Checklist for Residential Care

(See [Printable Resources](#) for the checklist)

This checklist is a self-directed guide to examining pain management practice at your facility. This should be conducted at regular intervals (to be determined by the facility) to ensure ongoing adherence to best-practice standards. Doing

this will help you identify current strengths in practice and highlight areas for improvement. We recommend that a structured plan be developed to address areas needing improvement, and to complete a follow-up audit to assess the implementation of that plan.

The [Pain Management Audit Checklist for Residential Care](#) is divided into five major themes:

- Implementing changes in pain management practice. i.e. readiness for change
- Pain management team and oversight
- Pain management tools
- Resources and education
- Treatment strategies and guidelines

Note that if you are using your own auditing system or a third-party benchmarking solution, check to see that the content on pain management is similar to this checklist.

H

Pain Action Plan for Residential Care

(See [Printable Resources](#) for the tool)

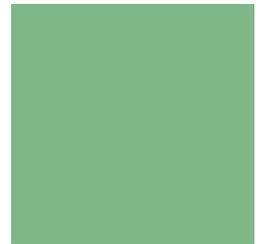
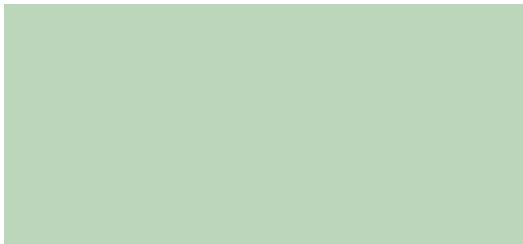
For providers to assess their organisational strengths and identify further areas of improvement, we recommend using the Pain Action Plan for Residential Care. This plan is an aspirational guide for providers in identifying potential areas that they can excel in pain management. The plan is divided into three levels of action – **fundamentals** (core actions that are promoted by the toolkit for better pain management), **moving forward** (actions that build on these fundamentals), and **industry leading** (actions recommended for providers to be flagships for pain management in aged care).

The [Pain Action Plan for Residential Care](#) is divided into five major themes:

- Education and Training
- Staffing
- Access / Resources / Teams
- Quality / Governance / Systems
- Communication

¹⁵ Refer to Chapter 10 of *Pain in RACF 2nd Ed* for more detail about quality indicators.

Section D: Pain Management



NAVIGATOR

[Section A: Toolkit Overview](#)

[Section B: About Pain](#)

[Section C: Systems and Governance](#)

[Section D: Pain Management \(4 Steps\)](#)

[Four Steps to Pain Management Flowchart](#)

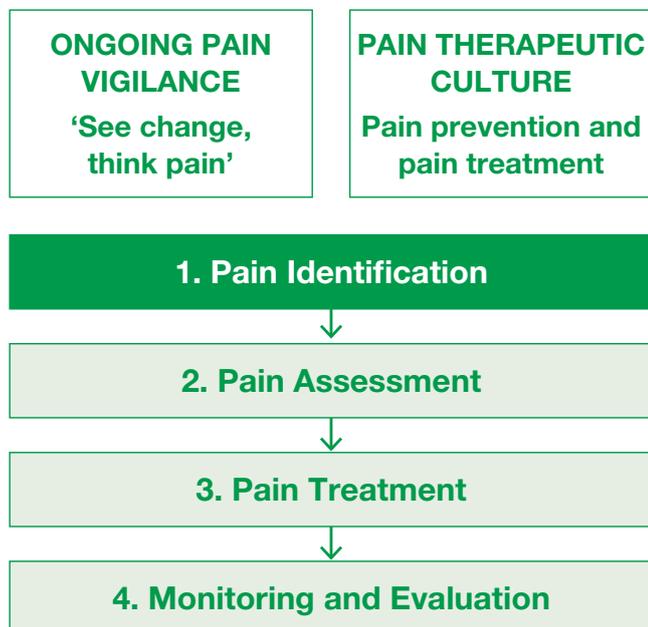
[Printable Resources](#)

or continue reading through this Section



Section D: Pain Management

Step 1: Pain Identification



See this section for:

- How to foster a pain vigilant culture in your facility
- How to predict, ask about and observe pain in residents
- Steps in pain identification
- Communicating with residents about pain
- Responding to beliefs or attitudes that can be a barrier to talking about pain
- Pain identification for people living with dementia
- Pain identification for residents at end of life

Relevant Printable Resources

General Handouts

- [Observed pain behaviours that may indicate pain](#)
- [Key principles for managing pain in older people](#)
- [Signs of Pain in Older People](#)
- [Identifying physical pain types](#)
- [The role of care staff in the pain management process](#)
- [Pain in dementia \(identification, assessment, treatment, evaluation and monitoring\)](#)

Fact sheets for residents and families

- [Fact Sheet 1 - Pain Management in Residential Aged Care](#)

Fact sheet for visiting general practitioners (GPs)

Fact sheets for aged care staff and health professionals

- [Fact Sheet 2 - Pain Identification](#)

Fact sheets for care workers

- [Fact Sheet 1 - Pain and Older People in Residential Care Facilities](#)
- [Fact Sheet 5 - Tips for reassuring residents about their pain](#)

Posters:

- [Pain identification and assessment flow chart](#)

Key summary

- **Pain identification** are the ways we notice that a resident may be in pain. Practicing pain vigilance means that staff are always on the look-out for signs of pain.
- All staff, residents and family members play a role in helping to identify if pain is present.
- Residents will have different levels of being able to or wanting to talk about their pain.
- Staff need to be aware of different ways that signs of pain can be expressed. Some residents may tell staff directly, but other residents (such as those living with dementia) will need closer observation for any 'pain behaviours'.

Pain identification refers to the ways in which anyone notices that a resident may be in pain. While some residents simply tell staff they have pain, other residents may be unable or unwilling to talk about their pain. Therefore, pain identification should not rely only on the resident saying they have pain (we call this ‘self-report’). Staff should always be looking out for ‘red flags’, or signs of pain. This helps foster a pain vigilant culture at your facility.

Though *pain identification* and *pain assessment* are often interwoven steps, these concepts have been separated in the toolkit.¹⁸ This is because pain identification is an important concept by itself, especially in residential aged care where many residents live with dementia.

All staff have an important role in identifying pain. PCAs are particularly well-placed to identify pain, as they usually spend the most amount of time with residents. When quality relationships and trust exist between staff and residents, residents are more likely to feel comfortable communicating that they are experiencing pain, and staff are more aware of any changes in a resident’s behaviour that may indicate pain.

What is a pain vigilant culture?

Pain can be easily missed in aged care facilities. A pain vigilant culture is much more than just adding pain assessment scales to routine clinical practice.

Pain vigilance is when everyone at the facility is constantly mindful of pain and works as a team to identify pain in a timely way.

Be **extra vigilant** for pain when a resident has any of the following¹⁹:

- Pain-related diseases (e.g. cancer, musculoskeletal conditions)
- Diseases predisposing to pain (e.g. Parkinson’s disease, diabetes, stroke)
- Gait impairments
- Falls
- Immobility (Contractures)
- Poor nutrition or weight loss (especially pressure ulcers, poor fitting dentures)
- Skin breakdown, pressure ulcers, wounds
- Procedures (surgical or otherwise) often accompanied by acute pain
- Dementia
 - Pay particular attention to signs of agitation and aggression, changed behaviours or other “behavioural and psychological symptoms of dementia” (BPSD)
- Concerns about pain from family

“See change, think pain.”

This motto comes from Napp Pharmaceuticals Ltd.¹⁶ For people living with dementia, challenging or changed behaviours may be the result of a person being in pain but struggling to communicate it. When we see a change in a person’s behaviour or condition, we consider ‘could it be due to pain?’ This is part of being ‘pain vigilant’.

“Pain is everyone’s business”

This motto from HammondCare was developed as part of an educational pain management program for people living with dementia.¹⁷ It neatly summarises that, in residential aged care, everyone is involved in the care of a person experiencing pain. This can be extended to include *all residents in aged care*, not just people living with dementia.

¹⁶ Pain in People with Dementia: A Silent Tragedy (<https://dementiaroadmap.info/wp-content/uploads/See-Change-Think-Pain-Napp-Report.pdf>)

¹⁷ See the Intervene Pain Education Program (<https://www.dementiacentre.com/intervene>) and report (https://www.dementiacentre.com/images/HammondCare_InterveneReport_2019.pdf)

¹⁸ Refer to Chapter 2 of *Pain in RACF 2nd Ed* for comprehensive information on best practice approaches to identifying and assessing pain.

¹⁹ Reproduced from Table 16 in Chapter 7 of *Pain in RACF 2nd Ed*.

Pain vigilance: Who is best placed to notice or identify pain?

Everyone involved in the care or wellbeing of the resident has a role to play in identifying pain.

- Most importantly, the **resident** is best placed to identify their own pain.
- **Family and friends** who spend the most time with the resident can provide insight into how they usually express pain and can indicate to staff if they think the resident may have pain. Quality communication between staff and family is crucial.
- **PCAs** generally spend the most time providing direct care. A resident may tell them about pain they are experiencing, or the PCA may notice changes in behaviour that might indicate pain. PCAs must be educated in the potential signs of pain and be vigilant. PCAs should be encouraged to report signs of pain, must feel they will be heard respectfully, and that they can raise concerns without fear of recrimination (for example, either being blamed or it is assumed their care has caused inadvertent or unexpected pain).
- **Lifestyle, food, laundry and cleaning staff or any non-clinical staff** that spend time with the resident might notice signs of pain at rest, during or after activities. Movement or activity can exacerbate pain, so all staff have a role in sustaining a pain vigilant culture.
- **Health professionals in collaboration with medical practitioners, nurses, physiotherapists, occupational therapist, speech therapists, and dentists** are also in a position to identify pain from a targeted assessment based on the resident diagnoses, medical history and examination from their professional practice perspective.

Can we predict who is more likely to experience chronic pain in aged care?

Any resident could potentially have pain. But staff should consider the following risk factors as these residents are more likely to have pain. This is particularly important with residents living with dementia or residents who cannot otherwise verbalise their pain experience.

- Female
- Age (pain is not a normal part of ageing, but age is a risk factor)
- Frailty (frail older people are less able to cope with, adjust to, or recover from health problems, including pain)
- Obesity (increased mechanical stresses can lead to musculoskeletal or joint pain)
- Depression
- Comorbidities (a number of conditions are associated with persistent non-cancer pain²⁰)
- Resident with intense emotions, or has a tendency to ruminate, worry, or catastrophise.
- Resident who had early childhood traumatic experiences
- Genetics (a number of genes play a role in our individual experience of pain)
- Resident with ongoing acute pain
- Resident has had high doses of opioid medications over a long time period
- Resident cannot move independently or is immobile for prolonged periods (risk of pain is due to immobility, as well as potential exposure to incorrect handling and transferring by staff)
- Resident at end of life
- Insufficient physical activity

²⁰ See Table 1 in Chapter 2 of *Pain in RACF 2nd Ed* for more information about non-cancer pain.

PRACTICE TIP: Building relationships with residents, being aware of changes and asking them about pain

Many older people are reluctant to report pain. They may not want to feel they are a burden to busy staff, they have had a poor experience in the past when they talked about their pain, they believe that pain is part of ageing and should be endured, or they are apprehensive about reporting pain as it may indicate a worsening of their condition or result in further testing or medical intervention.

Ask residents if they are experiencing any pain. Explain the reason for your interest and how they will have choice in any proposed management. Help the resident feel comfortable talking to you and that you want to understand what they are experiencing so that you can help.

Spend time building quality relationships with residents. When staff know a resident well, they will be able to notice changes or behaviours that are not normal for that resident. Some of these changes or behaviours may indicate that the resident has pain.

Social factors that may affect pain identification:

A number of social and environmental factors may impede accurate pain identification, including: barriers that are known to impede accurate pain identification. The following are some social and environmental factors.

Social diversity of residents and staff

- Lower educational levels

- Lower levels of health literacy
- Cultural, ethnic and linguistic differences

Staff workloads

- Overworked staff may feel pain identification is no longer a priority. Residents may feel that it is not worth speaking up about their pain if they think staff are too busy to address it with them.

Pain identification steps

Some basic principles apply when being vigilant for pain.

Active pain vigilance should be practiced when residents are:

1. At rest and during active or passive movement (e.g. during transfers),
2. At all times of the day and night.

Take note of when:

- A resident is concerned about their level of pain.
- A resident has had a potentially painful procedure or care regime that might trigger or exacerbate pain
- Social factors (see box on 'Social factors may affect pain identification' on the next page)

- And most importantly, what the resident says about their pain. **Self-report is the gold standard.**

Residents vary in their ability and willingness to talk about their pain. Broadly, there are three main groups in aged care.²¹ They are residents that:



Can and will tell us when they have pain



Will not tell us about pain by choice, or they may express pain differently



Cannot tell us about pain because of cognitive or communication deficits

²¹ Refer to Chapter 2 of *Pain in RACF 2nd Ed* for more information on these three groups.

How do we identify pain?

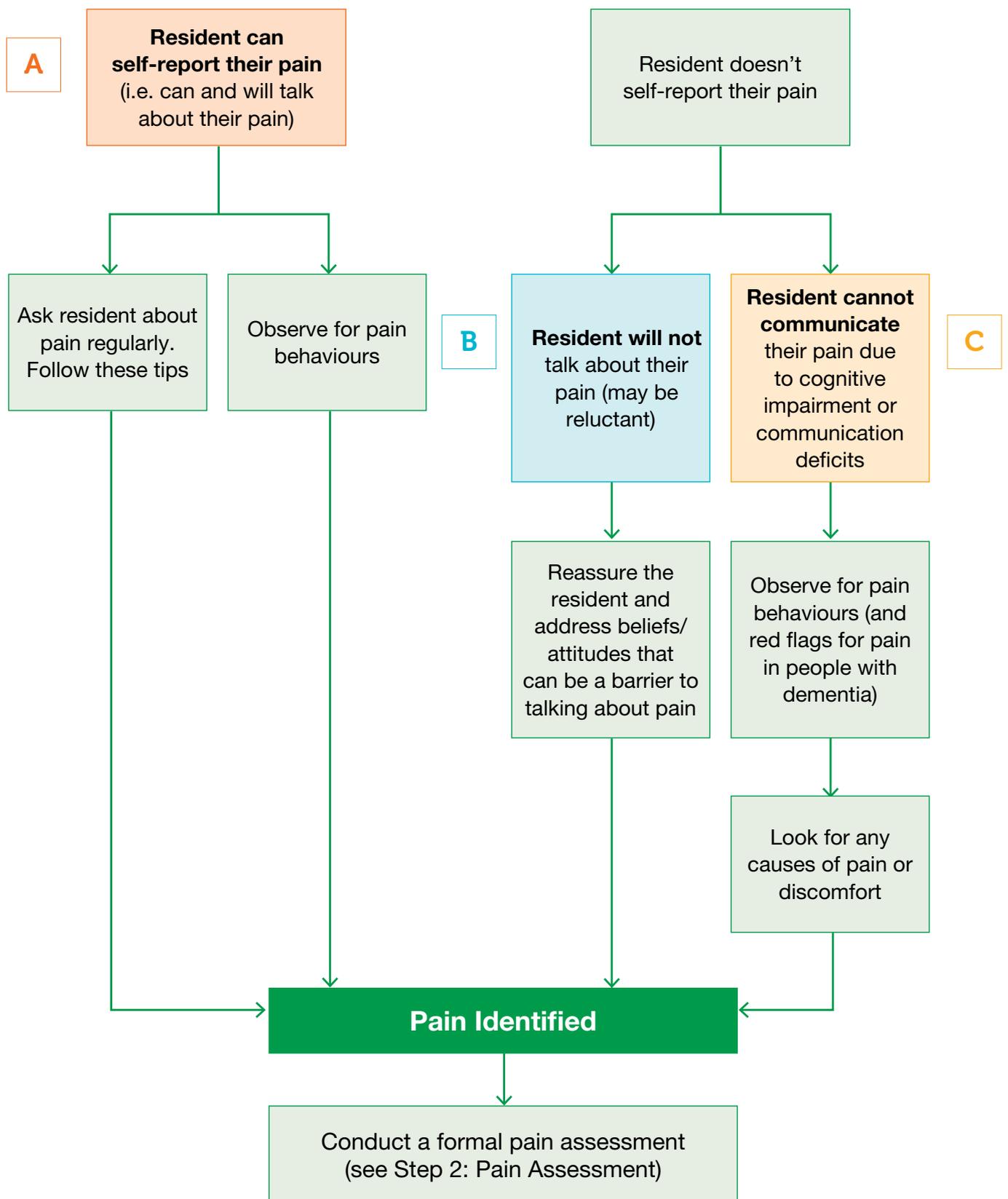


Figure 6: Pain identification flowchart. Always practice pain vigilance. When pain is identified (whether reported or observed), it is important to follow up and assess the resident's experience of pain (see Step 2: Pain Assessment).

A**For residents who can and will talk about their pain**

1. Self-report is the gold standard.
2. Give the resident time and opportunity on a regular basis to speak about their concerns, including pain. Ask all residents about pain while they are at rest as well as moving. Use words like “sore”, “hurting”, “aching”, as well as “pain”.
3. Be watchful for signs of pain when the resident is resting and also while moving.
4. If the resident reports pain or if their behaviour may indicate pain, explain the need for further assessment and proceed with appropriate assessment (see the section on Pain Assessment from page 37).

Tips when asking residents about pain:

- Allow the resident the time and opportunity on a regular basis to speak about their concerns including pain.
- Knowing and being trusted by the resident can help ensure pain is not missed or underestimated.
- Listen and document how the resident describes and understands their pain.

Observation for ‘pain behaviours’ is also important for all residents, whether they can/ will talk about their pain or not. Pain is often expressed verbally as well as behaviourally. A resident may say ‘it hurts’ whilst also gesturing or making facial expressions. Pain behaviours are actions by the resident that may be a reaction to the pain they experience. See [Printable Resources](#) for examples. Two common types of pain behaviours are:

**Protective gestures
(used to try to prevent or reduce pain)**

- Limping, holding, rubbing
- Guarding (trying to stop you from touching or moving a part of the body)
- Being unwilling to move or undertake an activity (such as rolling over)

**Communicative behaviours
(used to express their pain)**

- Facial expression (see [Printable Resources](#) from *Pain in RACF 2nd Ed* for examples of expressions that may indicate pain)
- Vocal sounds such as ‘ouch’ or groaning

B**For residents who will not tell us about pain by choice, or who may express pain differently**

Residents may not talk about their pain for a number of reasons, such as attitudes and beliefs, or they may express pain differently. If a resident is reluctant to talk about their pain due to attitudes or beliefs, then consider how attitudes are impeding communication and possible responses (see below).

Attitudes and beliefs that impede pain communication:

- That pain is an expected part of ageing
- That pain may suggest worsening disease or damage
- That complaining is a negative thing
- That chronic pain can't change
- That taking medication will lead to addiction
- That reporting pain will reduce permitted independence

How to respond to beliefs or attitudes that can be a barrier to talking about pain

Below are some practical examples of beliefs or attitudes that you may encounter and ways in which you might respond to encourage more helpful thinking.²²

Unhelpful belief or attitude	Example response
Thinking that pain is just a natural part of growing old	<i>Ageing does not cause pain: disease or health conditions do. There are many things we can do to support you so please don't suffer in silence.</i>
Fear about addiction to medication	<i>Your doctor and the staff here will monitor your medication regularly to ensure it is being safely used.</i>
Cultural factors around expressing pain	<i>We can respect your heritage whilst also managing your pain. Feeling sore or in pain can be a medical problem and not just part of the ageing process, so it is important that you let us know if you're experiencing discomfort. [Reassure the resident to reduce their fear of pain, for example, that hurt does not necessarily equal harm].</i>
Thinking that pain is outside their control	<i>Rather than focusing on what is outside your control, it might be more helpful to spend some time talking about what we can influence or control.</i>
Attitudes of stoicism (tendency to not show emotion) or feelings of embarrassment	<i>There is nothing to be ashamed about being in pain. It's understandable that you don't like to discuss your own problems, but we would like to help and support you. Because pain is invisible, we need you to tell us a bit about your experience.</i>
Perceived helpfulness of treatment	<i>The best approach to treating pain goes beyond using only medications. There are many things that can help manage your pain [Where possible, share an example of strategies that other residents have found helpful].</i>

²² Modified from Table 6 in Chapter 3 of *Pain in RACF 2nd Ed.*

C

For residents who cannot communicate their pain due to cognitive impairment or communication deficits

Observe all residents for possible signs of pain, including those signs seen in people living with dementia (see 'red flags' box):²³

Note: if the cause of pain seems to be something that can be easily remedied (e.g. shoes are uncomfortable, lying in an uncomfortable position), make adjustments where possible and monitor for improvement.

PRACTICE TIP:

- Indirect report is helpful if a resident is unable or unwilling to communicate pain
- Family and friends are a source of information about whether the resident is in pain

Red Flags for residents living with dementia.

The following 'red flags' may indicate pain:

- **Facial gestures***: Frowning, grimacing, sadness, tension, fear
- **Vocalisation**: Crying, groaning, moaning, swearing, verbal negativity, angry sounding or aggression
- **Body language**: Rigidity, guarding, bracing, fidgeting, restlessness, rocking, clenched fists, withdrawal, pulling or pushing, striking out
- **Behavioural changes**: Cognitive function, appetite, mobility, posture, range of movement, endurance, activity and fatigue

- **Physiological changes**: Vital signs such as temperature, pulse and respiration rate (TPR), blood pressure, perspiring, flushing or pallor
- **Physical injuries**: Skin tear, pressure injury, lesion to oral or rectal mucosa, dental pain, contractures, arthritis, distended abdomen, recent fall
- **Behavioural and psychological symptoms of dementia (BPSD)** may be a response to pain

**New mobile phone app technology can assist in detecting pain-related facial gestures automatically*

Pain identification for people living with dementia²⁴

People with dementia are as likely as other residents to experience pain related to co-morbidities as listed above. It must NOT be assumed that their pain is less bothersome or has less of an impact on them compared to residents living without dementia. We often do not fully know the pain experience of a person with dementia if they are unable to communicate easily with us. Therefore, be vigilant about any changes in behaviour or mood from what is normal for that person, and always consider that any change might be a sign that the person is experiencing pain.

Residents living with dementia:

- Are at risk of both under and over treatment of pain

- Each have their own individual pain history, and differing ability to recall or describe their pain and how it affects them
- Are relatively less likely to respond to the placebo effect of treatments (the placebo effect is the psychological benefit of a treatment. e.g. feeling the relief of treating the health problem and more hopeful of improvement)
- May express their unrelieved pain in ways that resemble changed behaviours (also called Behavioural and Psychological Symptoms of Dementia [BPSD])
- May have families and friends able to advise on previous pain and how this affected the resident's mood, function and quality of life

²³ See Printable Resources from *Pain in RACF 2nd Ed* for information on behavioural signs of pain.

²⁴ See Figure 3 in Chapter 2 of *Pain in RACF 2nd Ed*.

Changed behaviours in people living with dementia (e.g. BPSD) can often be in response to the pain they experience. Document observations and initiate a pain assessment appropriate for a person living with dementia (see the section on Pain Assessment from page 37 and Printable Resources).

Examples of BPSD that may be pain-driven behaviours include:²⁵

- Increased agitated or aggressive behaviour. Verbal aggression may include screaming, swearing, threats, and outbursts. Non-verbal aggression may include hitting, kicking, scratching, spitting and throwing objects. Verbal agitation may include constant requests for attention or help, constant complaints, expressing unrealistic fears,

repetitive questions or other repetitive verbalisations. Non-verbal agitation may include purposeless repetitive movements, general restlessness and inappropriate dressing or undressing.

- Increased resistance to care, such as a tense/rigid body posture or guarding of limbs, especially prior to, or during, care when moving parts of the body.
- Repetitive vocalisations such as moaning, groaning, muttering, sighing or grunting.
- Increased psychological symptoms of dementia such as anxiety, depression, confusion or delusions.
- Reduced levels of wandering.
- Withdrawn behaviours, reduced levels of activity or disengagement.

Pain identification for residents at the end of life

The timeframe implied by the term “end of life” is variously defined, but residential aged care facilities often consider end of life as the last weeks or days of life. During this time, palliative care aims to improve comfort and function and address the psychological, spiritual and social needs of residents with life limiting and irreversible illness, whilst respecting autonomy, dignity and choice.

End of life care²⁶ includes physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the body after death. People are ‘approaching the end of life’ if likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- advanced, progressive, incurable conditions
- general frailty and co-existing conditions that mean that they are expected to die within the coming months
- existing conditions, if they are at risk of dying from a sudden acute crisis in their condition
- life-threatening acute conditions caused by sudden catastrophic events.

Residents, families, and staff play a key role in noticing day-to-day changes that may herald end of life. See below for signs and symptoms that may indicate a resident is approaching the last days of their life. See the Pain Treatment section from page 46 for advice on medication use at the end of life.²⁷

Red flags at the end of life²⁸

Signs and symptoms indicating a resident is likely to be approaching their last days of life:

- Experiencing rapid day to day deterioration that is not reversible
- Requiring more frequent interventions
- Becoming semi-conscious, with lapses into unconsciousness
- Increasing loss of ability to swallow
- Refusing or unable to take food, fluids or oral medications
- Irreversible weight loss
- An acute event has occurred, requiring revision of treatment goals
- Profound weakness
- Changes in breathing patterns

²⁵ Reproduced from Table 19 in Chapter 7 of *Pain in RACF 2nd Ed.*

²⁶ <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-consensus-statement-essential-elements-safe-and-high-quality-end-life-care>

²⁷ Refer to Chapter 8 of *Pain in RACF 2nd Ed* for comprehensive information about pain at the end of life.

²⁸ From the Residential Aged Care End of Life Care Pathway (RAC EoLCP): https://metrosouth.health.qld.gov.au/sites/default/files/content/raceolcp_watermark.pdf

Case studies: admission and pain identification

Case study: Mario

Mario was 81 years old and had a diagnosis of Parkinson's disease when he was admitted to the residential aged care facility. Mario was diagnosed with Parkinson's disease when he was 78. On admission, Mario's daughter, Sylvia, told the nurse that Mario had limited English and was hard of hearing. Sylvia and her brother would often translate for Mario.

At this time, a comprehensive pain assessment was carried out for Mario (detailed in the assessment section of the PMG Toolkit 2nd Edition). At the time of admission, Mario reported some minor pain on movement. This was determined in consultation with the GP to be related to his Osteoarthritis and a treatment plan was developed including non-pharmacological therapies. Mario was given paracetamol before participating in any physical activity and this provided sufficient relief.

One month after Mario's admission, a PCA who had spent a lot of time with Mario noticed that he seemed to be becoming more withdrawn, was not moving around as much as usual, and was having trouble sleeping. The PCA tried to ask Mario if he was in pain using various words and signals, but Mario seemed confused and didn't understand the questions being asked. When Sylvia was visiting that afternoon, the PCA asked her to translate and speak to Mario. Mario admitted that he had pain in his lower back.

The PCA asked Sylvia to reassure Mario that the team at the facility would work with him to find the cause of the pain and to work out some strategies to help, and to encourage him to keep letting them know about his pain experiences so that they can help. The PCA documented what had been observed and what Mario had reported in his case notes, and also reported this information to a nurse on duty.

Case study: Margaret

Margaret was 88 years old and had diagnoses of dementia and ovarian cancer when she was admitted to the residential aged care facility.

On admission, Margaret's husband, Richard, expressed to the nurse that he was concerned about his wife's behaviour: she was often anxious and restless, and that he thought it may be to do with her dementia.

The nurse observed in the meeting that she was restless, unable to sit for any length of time, and was constantly fidgeting. She seemed tense and irritable in conversation. Although she could converse briefly and respond to questions, the nurse found that she had to keep her questions and comments short and simple otherwise Margaret would lose track of the conversation.

Richard indicated in conversation that Margaret had been reluctant to complain about experiencing any pain or to seek help over many years during illness.

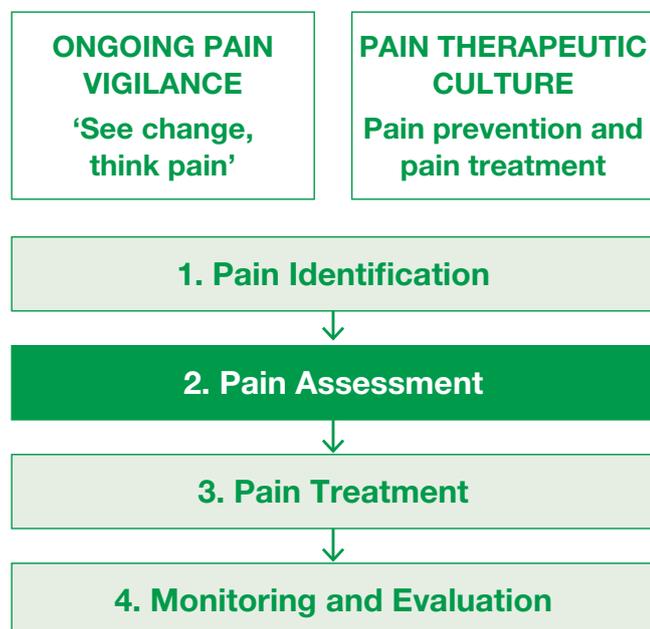
The nurse asked Margaret a few questions including: 'are you in pain?', 'are you feeling uncomfortable?' and 'do you have any aching or soreness?', but Margaret seemed defensive and irritable.

The nurse reassured Margaret and told her that it was normal to experience pain and that there were many things the team at the facility could do to help. After this, Margaret appeared to settle somewhat but still didn't answer the questions about pain.

The nurse initiated a comprehensive pain assessment for Margaret, in the presence of Richard.

Section D: Pain Management (continued)

Step 2: Pain Assessment



See this section for:

- Guidance on when, why and how to do a pain assessment
- The importance of person-centred pain assessments
- Who is responsible for pain assessment
- Conducting a pain assessment interview
- Types of pain assessments
- Pain assessment scales – for residents who can and cannot communicate
- Pain charting
- Pain assessment at end of life

Relevant Printable Resources



General Handouts

- [Example questions to ask during a comprehensive pain assessment interview](#)
- [Factors relevant to comprehensive pain assessment](#)
- [Observed pain behaviours that may indicate pain](#)
- [Signs of Pain in Older People](#)
- [Identifying physical pain types](#)
- [The role of care staff in the pain management process](#)
- [Pain in dementia](#)
- [Pain assessment scales](#)
- [Pain Care Goal Plan](#)
- [Aged Care Pain Chart template](#)

Fact sheets:

For residents and families

- [Fact Sheet 1 - Pain Management in Residential Aged Care](#)

For aged care staff and health professionals

- [Fact Sheet 3 - Pain Assessment](#)

For care workers

- [Fact Sheet 2 - Assessing Pain](#)

Posters:

- [Pain identification and assessment flowchart](#)

Key summary

- **Pain assessment** aims to measure pain, understand the cause of pain, and how the resident experiences pain and is impacted by it.
- Ongoing pain assessment and continuous pain vigilance is important for optimal pain management.
- Pain assessments can be conducted as part of routine care, or in response to new/changing

pain being reported or identified. These may include an interview and physical examination.

- **Pain assessment scales** can be used to assess each resident's pain. Some scales are designed to be used with residents who can self-report, and others are designed to be used with residents who cannot communicate effectively.
- **Pain charting** can be used to monitor and document pain over a brief time period.

Pain identification ultimately aims to answer the question: “is there pain?” If the answer is “yes”, or probably, then **pain assessment** measures it, understands the cause, and evaluates how the resident is impacted by pain.

Pain assessment is a fundamental step in pain management. While identification of pain is often the trigger for conducting a pain assessment, pain assessments should also be conducted at specific times (see later for when to conduct a pain assessment).

Why do a pain assessment?

Optimal pain management requires ongoing pain assessment. The process of pain identification, assessment, treatment and evaluation is a continuous cycle. Comprehensive pain assessments gather all the necessary information to better understand where the pain is and its cause. These assessments are bio-psycho-social when also evaluating the psychological, social and physical impacts of pain on the person. A clear pain treatment plan can then be developed, and progress monitored with what the resident hopes to achieve from the treatment plan.

Person-centred pain assessment

Getting to know each resident – their background and life experiences as well as their pain history – promotes a pain vigilant and pain therapeutic culture by learning how each individual person normally expresses themselves and communicates their feelings and needs. This aspect of person-centred care allows us to be aware of any changes that may signify pain or needing some other support. This is the first step to developing a pain management plan specific to each person’s needs so that the best possible treatment is provided.

Overall, pain assessment aims to understand the factors that may be contributing to or resulting from the person’s experience of pain in order to develop a pain management plan. This is achieved through interviews with the resident or their representative, a physical examination and using assessment tools.

Who is responsible for pain assessment?

Pain assessment is a team effort and benefits from multidisciplinary input. Capable staff, regardless of role, can conduct an interview with residents and/or their representatives.

In some settings, care staff may be trained to use some of the pain assessment tools or document residents’ responses to standard follow up questions. Nurses will be more likely to complete pain assessment tools and PCAs to document pain charts.

If a physical examination is needed, this is to be done by a nurse, doctor, physiotherapist or another appropriate health professional.

When to conduct a pain assessment

Routine pain assessments (to be done even if no pain has been identified):

- On admission for every new resident: do a detailed medical and pain history and a physical examination
- After any fall or near fall even if no immediate injury is present
- After any injury, surgery, medical procedure or care regime that may be associated with pain
- After any new diagnosis or progression of disease that may be associated with pain
- If there are any changes to the resident’s medical or physical condition
- Every three months (e.g. with the Resident of the Day) or weekly for people living with advanced dementia (using a brief assessment scale).

Pain assessment triggered by pain identification or as part of ongoing pain management:

- As soon as any concerning or significant pain is identified or suspected, including:
 - When the resident says they have pain or levels of existing pain have changed
 - When staff raise concerns about pain
 - When family or representatives raise concerns about pain

- Prior to any new pain treatment or medication – this baseline assessment is then compared to subsequent assessments to evaluate treatment effectiveness (see [Monitoring and Evaluation](#), from page 69).

- Post-treatment pain charting is typically conducted after starting or altering a pain treatment or medication – the length of time needed before post-treatment pain assessment will vary depending on the treatment.

How to do a pain assessment

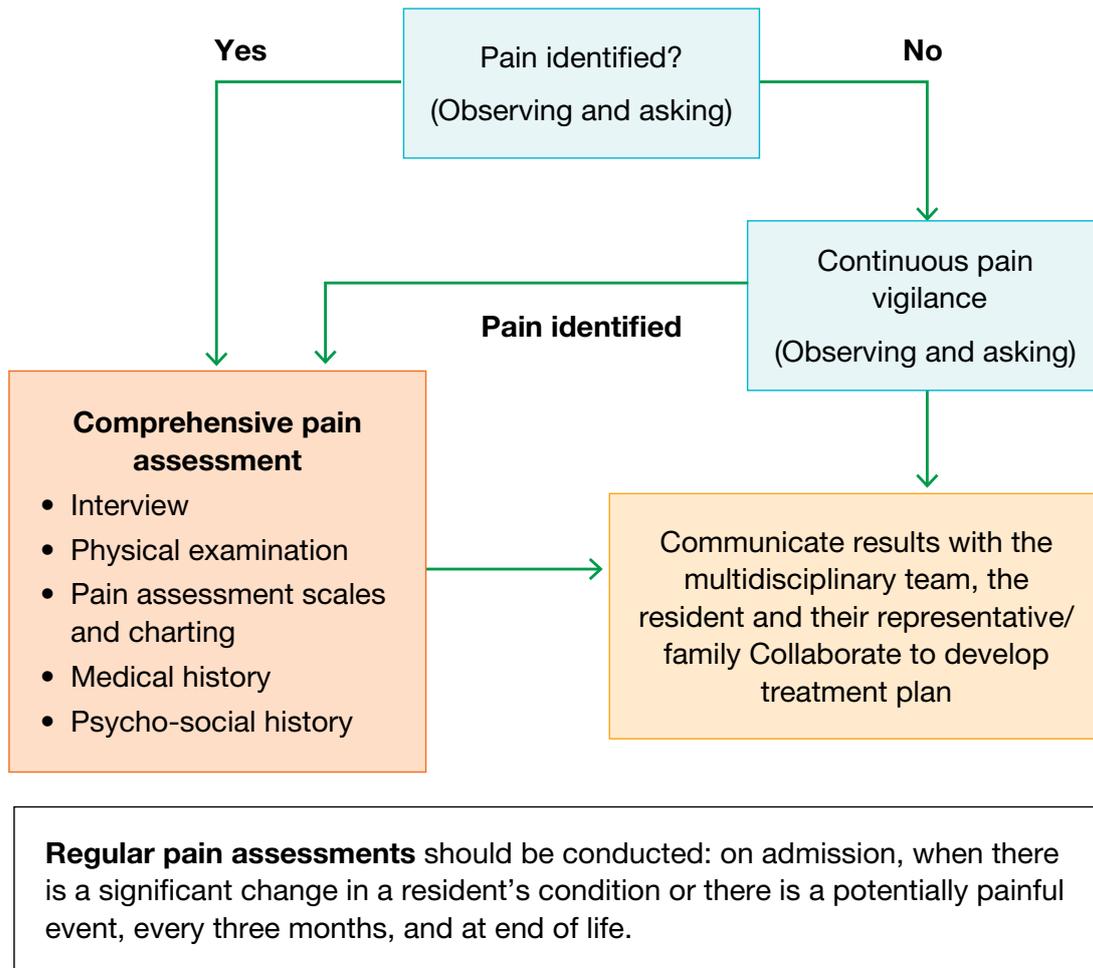


Figure 7: Process of pain identification and assessment

Always be vigilant for signs of pain: observing and asking

As described in the previous step (Step 1: Pain Identification), staff must always be observing for any changes in behaviour that may indicate pain, as well as regularly ask residents or their representatives about pain. Asking may be part of casual conversation or part of routine pain assessments.

Some example questions to ask include:

- Do you have pain anywhere right now?
- Do you feel sore anywhere right now?
- Are you aching or hurting anywhere right now?

Use a variety of words in addition to “pain” (such as “sore”, “aching”, or “hurting”) as different people may have different interpretations of these words.

- If the resident indicates there is no pain, the pain assessment ends here and will be revisited at the next routine assessment. Continuous pain vigilance must be practiced in the meantime.
- If the resident says that there is pain that has been assessed before and is currently being treated and managed, the pain assessment also ends here with continued monitoring of the known pain.

- If there is some new or previously unreported pain present, conduct a comprehensive pain assessment to learn more about the pain the resident is experiencing. This will help develop a treatment plan.

The results of all pain assessments must be clearly documented, even if no pain is identified.

A pain assessment is conducted if new or changed pain has been identified

The next steps include understanding the resident’s experience of pain through a **comprehensive pain assessment**. A comprehensive pain assessment is a combination of interview, examinations, reviews, and pain assessment scales. It will include some to all of the elements shown in Figure 8. These should generally aim to answer the “what”, “where”, “when”, “how”, and “why” of the pain. Also ask how the resident feels about the pain and in what ways it limits them from doing things they want to do. Everyone experiences pain differently and each individual resident may have different levels of pain sensitivity or have a different psychological response to pain.

Comprehensive pain assessment

Interview

Pain History

Use the OPQRST approach (see below)

Psycho-Social Factors

Attitudes, beliefs, mood, relationships (also see the bio-psycho-social approach)

Examinations

Physical Examination

Sites of pain, mobility, musculoskeletal and neurological system, frailty (see below)

Other Investigations

Blood tests, imaging

Reviews

General Medical History

Relevant co-morbidities, falls, other symptoms

Review of Medications and Current or Past Treatments

Pain Assessment Scales (including the use of multidimensional assessment scales)

e.g. Self-report assessment scales, observational assessment scales and pain charting



The result of a comprehensive pain assessment is to diagnose and characterise the What, Where, When, How, and Why, as well as the Multidimensional Impact, of each person’s unique pain problem

Figure 8: Adapted from Printable Resources accompanying Pain in RACF 2nd Ed: “Components of a comprehensive pain assessment”.

Interview

Staff should have a detailed discussion with residents about their pain experience. For residents who are unable to communicate successfully, discuss with their representative or family.²⁹

Use the OPQRST approach when asking a resident about their **pain history**:

- **Onset:** When and how did the pain begin?
- **Palliative/provoking factors:** When do you have pain? What are you doing when it happens? What makes the pain better or worse?
- **Quality:** Can you describe the pain (e.g. numb, electric, pinching, shooting, tingling, etc.)
- **Radiation/Region:** Where is the pain? Does it radiate anywhere?
- **Severity:** How much does it hurt?
- **Temporal:** How long have you had the pain and does it change in intensity over time?

Background information and context can help understand the cause of pain and in what ways the resident is affected by it physically, psychologically and socially (see bio-psycho-social model on page 9 and [Printable Resources](#)). Discuss what the resident is hoping to achieve with pain management – what must happen for them to feel their pain is being managed successfully?³⁰

Interviewing people with dementia or are otherwise unable to communicate successfully

Communicative residents with mild or moderate dementia may have trouble recalling their past or recent pain experiences, so tailor the discussion to their abilities. A joint or additional discussion with their representative may help fully understand the resident's experience. Care and nursing staff may be able to provide insight as well.

- Use simple and direct language
- Ask what the resident is experiencing now (“Are you in pain right now?”). Avoid asking about past pain or comparing current pain to

pain in the recent past (e.g. avoid “Did you feel pain last night?” or “Does it hurt more today than it did last week?”)

- **Avoid** asking about past pain or comparing current pain to pain in the recent past (e.g. avoid “Did you feel pain last night?” or “Does it hurt more today than it did last week?”)
- Give the resident enough time and space to respond
- Make sure the environment is comfortable (e.g. good light, minimal distractions) and the resident has everything they need to have the discussion (e.g. hearing aids, glasses)
- Use words other than “pain” to help the resident understand and respond, for example: ache, hurt, sore, uncomfortable, tender
- Ask the person to point to where it hurts, if possible

When a resident cannot meaningfully self-report their pain, rely on observing their behaviour and responses both at rest and during movement. Signs of pain may include grimacing, guarding or groaning during personal care or movement. Determining when residents show pain responses will help figure out when and where residents have pain, and then decide how to treat and/or manage it.

Physical examination

The physical examination aims to observe the severity of the pain as well as when and how it presents. This is to be done by a nurse or doctor. Additional examinations can be done by a physiotherapist or other health professional as needed.

The examination should be done while the resident is at rest or not moving (e.g. sitting, lying in bed, standing still, etc.) and also while the resident is moving or being moved (e.g. standing up, getting out of bed, being transferred or repositioned, etc.). Some movements may exacerbate pain and limit functional ability, which can make some residents reluctant to move or do certain things.

²⁹ Refer to [Printable Resource: “Example questions to ask during a comprehensive pain assessment interview”](#) for more example questions.

³⁰ Refer to page 51 of this PMG Toolkit for information on Pain Care Goal Plans.

The physical examination includes³¹:

- Sites of reported and referred pain
- Musculoskeletal system and signs of arthritis or inflammation, or signs of fragility fracture
- Assessing mobility
- Neurological system, including weakness and sensory changes, loss of weakness in bladder or bowel control
- Degree of frailty

Make sure to communicate the results of the pain assessment to the rest of the multidisciplinary pain team, including the resident and their representative/family. This includes next steps, prognosis and ongoing monitoring.

It is important to practice continuous pain vigilance to identify any new or changed pain between assessments.

Pain assessment scales

Many different types of pain assessment tools are available. Choosing which one to use depends on the needs and abilities of each individual resident. Multidimensional tools (that assess not only the intensity of pain but also the impact of that pain) should be used during a comprehensive pain assessment.

Uni-dimensional tools (that only measure how severe the pain is) are appropriate for ongoing evaluation of pain intensity and for monitoring a person's response to treatment. Tools that rely on resident self-report are best suited for residents who are verbal and can communicate successfully, while observational tools are best suited for residents who are unable to communicate successfully. It is also for these residents that extra pain vigilance must be practiced to observe any potential signs of pain. Once a tool has been selected for a particular resident, continue using that same tool every time for that resident.

Self-report: For residents who are able to communicate

Self-report pain assessment tools are the gold standard.³² These allow residents, including those living with mild to moderate dementia, the opportunity to share what and how they feel. Staff must enable and assist residents to communicate for as long and as much as they are able. This requires careful and skilled communication with appropriate body language from staff in active listening, sharing findings with the rest of the team, and clear documentation.

Uni-dimensional and multi-dimensional scales are available. Uni-dimensional scales assess

Unidimensional Scale

Numeric Rating Scale (NRS)³²

Residents rate their pain on a scale of 0-10, where 0 indicates no pain and 10 indicates the worst possible pain.

Verbal Descriptor Scale (VDS)³²

Resident categorises their pain with words, such as 'no pain', 'mild', 'moderate', 'severe', 'very severe' or 'worst possible pain'.

Multidimensional scales

Modified Resident's Verbal Brief Pain Inventory (M-RVBPI)³²

A bio-psycho-social scale developed for residential aged care. Residents rate pain severity and location. Residents also rate the physical and psycho-social impacts of pain on their general activity, mood, relations with others, walking ability sleep, and enjoyment with life. It can be used for the initial pain assessment as well as for ongoing monitoring.

³¹ Adapted from a Printable Resource accompanying *Pain in RACF 2nd Ed*: Components of a comprehensive pain assessment interview.

³² See online Appendices from *Pain in RACF 2nd Ed* for copies of the NRS, VDS and M-RVBPI.

only one aspect of pain (typically the severity of the pain). Multi-dimensional scales assess more than one aspect of the pain (e.g. not only how severe is the pain, but also the impact on the resident, such as their mood or quality of life).

Observational: For residents who are not able to communicate

Observational pain assessment tools are generally used for residents living with advanced dementia or other conditions that limit their ability to meaningfully self-report their pain. These non-verbal tools assess pain by observing facial expressions and behavioural responses.

Abbey Pain Scale³³

Records the severity and frequency of observed vocalisations, facial expressions, changes in body language or behaviour, and any physiological or physical changes.

Pain Assessment in Advanced Dementia (PAINAD) Scale³³

Records severity of the following things after 5 minutes of observation under different conditions: breathing independent of vocalization, negative vocalization, facial expression, body language and consolability.

New technologies in pain assessment

New mobile and tablet apps have been developed to improve pain assessment in people living with dementia. Common to almost all elements of paper-based observational pain scales are looking for the three major indicators of pain: facial gestures, verbalisations/vocalisations, and body movements. Mobile apps automate some of these processes. For example, an app may briefly record and analyse facial gestures by using facial recognition software to identify the presence of pain and estimate its severity. When starting to use or test these apps, the core principles when assessing pain in people with dementia still apply: use validated pain scales (self-report or observational), assess for signs of pain both at rest and during mobilisation, and remember that pain and BPSD are associated³⁴.

Pain charting

Each residential aged care facility will have its own methods of recording and documenting pain identification, assessment and treatment for each resident. Consistent record-keeping in resident files is needed as ongoing pain assessment is a key element of optimal pain management, and enables monitoring and evaluation of the pain management approaches for each resident.

A pain chart template (the [Aged Care Pain Chart](#)) suitable for use in residential aged care is available in Printable Resources. Instructions on how to use it are on the reverse side.

The Aged Care Pain Chart, developed in Australia, is useful for monitoring a resident's pain over a brief time period (e.g. a 24-hour or 3-day pain monitoring). Pain charting is time intensive and should be used when pain is (or suspected to be) a significant problem. When pain is not a significant problem, routine charts or assessments can be used instead.

³³ See [online Appendices](#) from *Pain in RACF 2nd Ed* for copies of the Abbey Pain Scale and PAINAD, along with instructions on observed behaviours that may indicate pain.

³⁴ Refer to Chapter 7 of *Pain in RACF 2nd Ed* for more detail about special considerations for people living with dementia.

How frequently a resident is monitored using the Aged Care Pain Chart is left to clinical judgement. For example, it may be appropriate to monitor pain once or a few times a day, after a significant event (such as a witnessed or suspected fall), before or after wound dressings, during physical activity, or to evaluate treatment response (such as when a new analgesic is administered). For people living with dementia who cannot verbalise their pain, the threshold for when to use the Aged Care Pain chart is lower (i.e. closer and more frequent monitoring is necessary).

Pain assessment at end of life

The process of pain assessment does not change when a resident is coming to the end of their life, but pain management goals do change. At this stage, palliative care aims to prioritise comfort and function, and address their psychological, spiritual and social needs.³⁵

Ongoing pain assessment is important for optimal pain management – this means that the process of identification/assessment/treatment/evaluation is a constant cycle

Case studies: pain assessment

Case study: Mario

The pain assessment that was conducted on admission included an interview (Mario's children assisted with translation) and completion of the M-RVBPI. At admission, Mario reported that his pain was under control with his currently prescribed medications and that he was comfortable. The outcome of the assessment was clearly documented in Mario's case notes.

After the PCA notified the nurse about what was observed and what Mario had said indicating that he was in pain, the nurse initiated another comprehensive pain assessment.

An interview was conducted with both of Mario's children present to translate. Mario was asked about the nature of his pain and how it was impacting on things like his sleep, mood, appetite and ability to do things. Mario described that he had sharp pains in his back as well as some aching that was quite severe at times. He said that it often interfered with his sleep and that he was hesitant to move around as much as normal because he was afraid the pain would get worse.

Because the M-RVBPI was used for Mario's pain assessment on admission, it was used

Case study: Margaret

The nurse initiated a comprehensive pain assessment, beginning with initial interview to ask Margaret some questions about what she was experiencing. Although Margaret was able to answer some of the questions in a limited way, the nurse decided to interview Richard separately. Richard was able to provide detailed information about his observations of Margaret's behaviours that may be signs of pain.

Richard was asked a series of questions using the Abbey Pain Scale including 'Have you noticed Margaret whimpering, groaning or crying?' (vocalisation) and 'Have you noticed Margaret looking tense, frowning or grimacing?' (facial expression). Richard detailed, to the best of his recollection, moments when he had observed those things. It was determined that Margaret's behaviours were expressions of her pain, rather than BPSD.

Only relying on self-report of pain would be an unreliable measure for Margaret because she was reluctant to report her pain and had some difficulty communicating. In consulting with Richard

³⁵ Refer to Chapter 8 of *Pain in RACF 2nd Ed* for extensive guidance on pain at end of life.

again on this occasion for comparison. Results from the completion of this scale confirmed what Mario had said in the interview.

The nurse documented all information gained from the assessment, and passed it on to the GP. The GP also administered the King's Parkinson's Disease Pain Scale (KPPS) to assess aspects of Mario's pain specific to his disease.

A physiotherapist conducted physical examinations of Mario while he was at rest as well as while he was moving. As Parkinson's Disease and associated pain is quite complex, Mario was referred to the Parkinson's Disease Association for further consultation.

It was determined that Mario's pain was related to his Parkinson's disease diagnosis. Mario was already taking medication for this, primarily dopamine agonists. He was also taking paracetamol regularly before physical activity. It was apparent, however, that this treatment was no longer working to manage his pain sufficiently.

The nurse, GP, physiotherapist and PCA planned a meeting with Mario and his children to develop a comprehensive treatment plan.

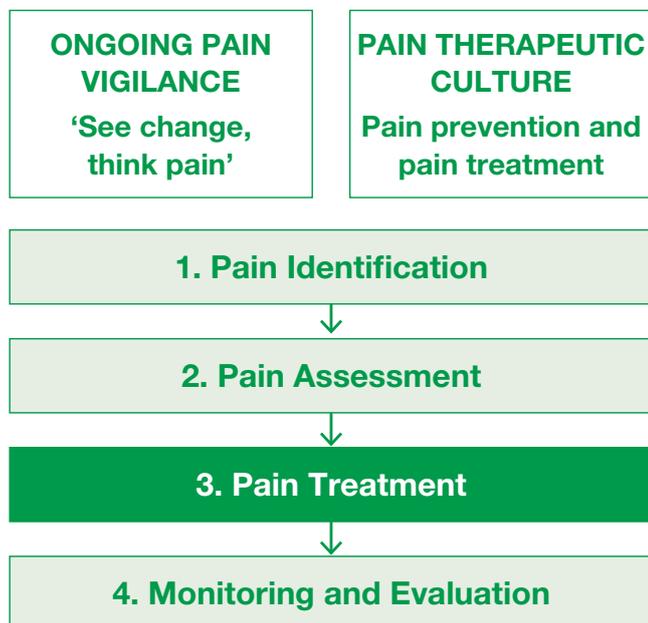
and conducting a comprehensive pain assessment, the nurse was able to gain a clear picture of the signs of Margaret's pain, and Richard was helped to understand Margaret's behaviour and why she was less likely to talk about the pain and discomfort she had been experiencing.

The assessment revealed that Margaret was experiencing increasingly severe aching pain, mostly in her lower body, while she was moving as well as resting. She was also experiencing fatigue, weakness and some nausea. Margaret had believed that the pain and discomfort were just things she had to 'deal with', but was reassured to learn that the staff could help her alleviate some of these things.

The GP read through the notes from the assessment as well as Margaret's medical history notes. Margaret was referred to the hospital where she had been receiving treatment for further assessment and scans, which confirmed that she had bone metastasis associated with her cancer.

Section D: Pain Management (continued)

Step 3: Pain Treatment



See this section for:

- Guidance around fostering a pain therapeutic culture in your facility
- Person-centred pain treatment
- Steps in creating a pain treatment plan
- Using Pain Goal Plans
- Selecting the right pain treatment
- Pain management for people with dementia
- Non-pharmacological approaches
- Pharmacological approaches
- Clinical concerns and medications
- Pain treatment for residents at end of life

Relevant Printable Resources



General Handouts

- [Pain Care Goal Plan](#)
- [Managing constipation](#)

Fact sheets for residents and families

- [Fact Sheet 2 - Opioid Medications](#)

Fact sheet for visiting general practitioners (GPs)

Fact sheets for aged care staff and health professionals

- [Fact Sheet 4 - Non-Pharmacological Pain Management Strategies](#)
- [Fact Sheet 5 - Pharmacological Pain Management Strategies](#)

Fact sheets for care workers

- [Fact Sheet 3 - Pain Management without Medicine](#)
- [Fact Sheet 4 - Pain Management with Medicine](#)

Posters:

- [Excellent Pain Management Requires More Than Medication](#)

Assessing Nutritional Status:

- [Tips for using the Subjective Global Assessment \(SGA\) and SGA tool](#)
- [Tips for using the Mini-Nutritional Assessment \(MNA\) and MNA-SF tool](#)

Key summary

- Encourage a pain therapeutic culture focused on person-centred care
- It is not always possible to eliminate pain 100%, but it can be managed to tolerable levels.
- Pain Goal Care Plans help direct staff to develop pain treatment plans by making appropriate and realistic goals based on what residents wish to achieve with their pain management.
- Pain management is most effective when combining non-pharmacological and pharmacological approaches. In some cases,

non-pharmacological approaches can be used alone.

- Non-pharmacological approaches include: psychological and educational approaches, movement and physical activity, nutrition, sleep, and complementary and integrative medicine (CIM).
- When using pharmacological treatments (i.e. medications): start low, go slow; less is more in older adults; keep analgesia simple but multimodal; and every person responds differently to medications.

Once pain has been identified and assessed, a pain management plan can be developed to incorporate the most appropriate methods of treatment for each person.

A simple physical or medical approach to severe, long-lasting chronic pain often does not work.

What is a pain therapeutic culture?

A pain therapeutic culture exists when staff attitudes and actions reflect that pain management is embedded in the workplace culture. That is, the facility is invested in managing each resident's pain as part of the daily care routine, supported by policies and procedures that grow a nurturing and respectful environment. This supports the most appropriate and evidence-based care for each resident.

A pain therapeutic culture is one that:

1

...assumes that the majority of residents are in pain or prone to pain

2

...is proactive in embedding multi-modal pain prevention in its daily routines (see page 48)

3

...uses the core principles of treatment for any type of pain (See Steps A to F)

4

...selects the right pain treatment/s

- Non-pharmacological
- Pharmacological
- Complementary and Integrative Approaches

Proactive Multi-Modal Pain Prevention as part of a Pain Therapeutic Culture

Being proactive in pain prevention is an essential part of a strong pain therapeutic culture.

Protecting the physical and psycho-social wellbeing of residents is crucial for preventing pain. **Early intervention is key.** Even residents with advanced medical conditions benefit from preventative measures that can stop their pain worsening. Avoid particular risk factors that can trigger the development of chronic pain. [See the Printable Resources.](#)

Psychological and educational approaches

Psychological factors including depression, anxiety, and attitudes and beliefs about pain can put people at risk for worsened chronic pain. Reduce stress and anxiety, provide relief for depression, and address non-constructive attitudes and beliefs to alleviate the pain experience. See the section on [psychological and educational approaches](#) (page 54) for more information about how to manage psychological factors for residents.

Movement, physical activity and activity performance

Movement and physical activity build and maintain confidence in moving, a sense of agency and independence, strength, and flexibility. Strategies that promote pacing, flare management and a graded approach (e.g. beginning with easy movement and activity, then gradually increase difficulty) will prevent overexertion. Overexertion may lead to a decrease in confidence and prevent a resident from wanting to continue with a movement-based approach.

Physical activity benefits residents in many ways. It slows physical and cognitive deterioration, shifts attention away from pain or physical emotions, and helps develop positive active coping strategies. It can also improve mood, and encourage meaningful socialisation and connection. Activities valued by the resident can provide purpose and improves emotional wellbeing and psychological functioning. Emphasise residents' function and valued activities as a form of therapy. See the section on movement and physical activity (page 56) for ways to assess and encourage [movement and physical activity](#).

Nutrition

Encourage and implement good nutrition and healthy weight to keep muscles and bones working well. Poor nutrition may promote painful conditions and start a cycle of not eating due to pain, and pain getting worse because of inadequate nutrition. Ensure that all residents are adequately nourished and hydrated. See the section on [nutrition](#) (page 61) for more information.

Sleep

Disturbed sleep and resultant fatigue may lead to increased pain. Monitor, manage and support good quality sleep for all residents. See the [sleep section](#) (page 63) for ways to help residents get enough good quality sleep.

Core principles of treatment for any type of pain

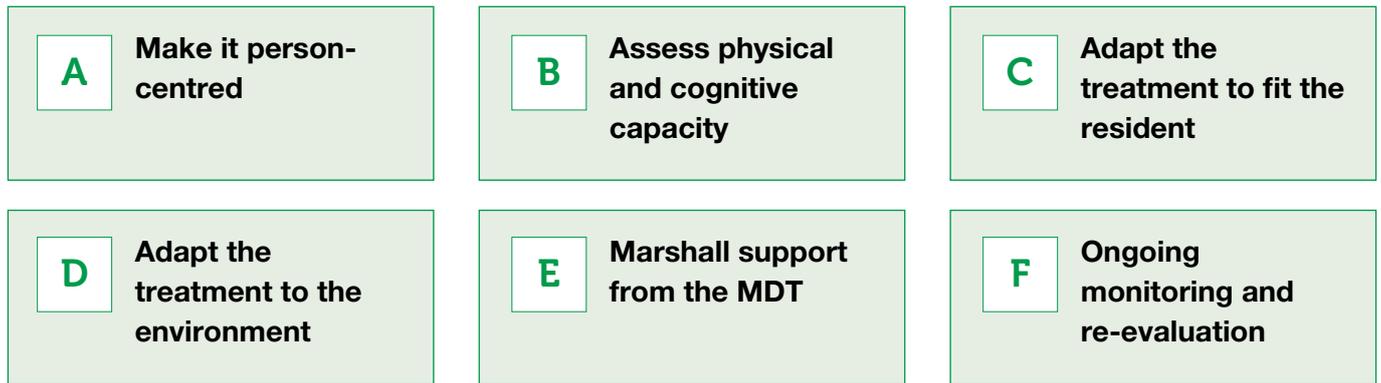


Figure 9: Core principles of treatment for any type of pain

A Make it person-centred

A person-centred approach supports and enables the resident to engage in their own pain treatment. Treatments are more effective when a resident is actively engaged rather than a passive recipient.

Consider what the resident wants to achieve with pain relief and what expectations they have. Useful questions to ask a resident include:

- What are their goals of care?
- How do they feel about their pain? How does their pain affect their life?
- What are their attitudes to particular types of pain treatment?
- Is there anything that they feel is preventing the management of their pain?
- Do they (or the family) see 'success' as the 100% elimination of pain?
- What is most important to the resident to achieve in the management of their pain? (e.g. pain relief and comfort, or being able to resume particular activities?)

Establishing realistic goals with the resident in light of their values, culture, beliefs and preferences is an important component of a treatment plan.

Realistic and achievable goals are an important component of a treatment plan. Create a treatment and goal plan in consultation with the resident and their family or informal carer.

Include the resident and family as much as possible. The toolkit includes a template for developing a [pain care goal plan](#) (see [Printable Resources](#) for a copy; see page 51 for more details). Wherever possible, this template should be completed as part of each resident's overall treatment plan.

100% Pain Elimination?

The complete elimination of chronic pain for a substantial amount of time is generally not possible. But pain can be reduced to tolerable levels so that the person can function at a level acceptable for them. Respectful two-way communication between the clinical care team and the resident will help: the resident needs to feel that they are being listened to, that their symptoms are being thoughtfully considered, and that the team cares about their suffering from pain and is doing their best to help. Educating the resident and addressing unrealistic expectations, combined with compassion and empathy from the care team are all important components of pain management.

B Assess the physical and cognitive capacity of the resident

Frailty, physical capacity, change in care needs and cognitive capacity are factors that may limit the efficacy of a pain treatment. For example, non-pharmacological therapies such as psychological and educational approaches may be of limited

useful for some residents living with advanced dementia. Exercise may need modification for residents with reduced physical capacity.

C

Adapt the treatment to fit the resident, and not the other way around

Personal, social and cultural beliefs of the resident are factors that can impact treatment effectiveness and adherence to the treatment plan. In these cases, these beliefs should be identified and addressed in collaboration with the resident. For example, complementary and integrative medicine (CIM) could be a stronger consideration for residents with a cultural background where CIM is often incorporated into treatment plans, and quality of life can be improved by resident's active involvement in their preferred treatment modality.

D

Adapt the treatment to the environment

Pain treatments may need to be adapted to fit the residential aged care environment. This environment includes not just the physical environment (such as the living space and open areas), but also other aspects such as the facility staff-skill mix, how daily routines are coordinated at the facility, and the organisational culture. Pain treatment needs to be adapted to ensure that it is fit-for-purpose and embedded into daily routine (e.g. physical activity treatments could embed walking to the dining room as part of the treatment plan).

E

Marshall support from the multidisciplinary team

Pain treatment is a team effort. Consider what support structures from other staff are currently in place or can be put in place? What role can volunteers and the resident's friends or family have? (See Box: 'How families can assist with pain treatment')

F

Ongoing monitoring and re-evaluation

We cover this important step later (Step 4 of the 4 steps to pain management, from page 69).

How families can assist with pain treatment

Family members, informal carers or other representatives can support residents with their treatment plan. Staff need to explain the treatment plan to the resident and family and ask for their help and input, including asking about preferences and previous coping styles.

Invite families to be involved, explain the pain management plan, and ask for their help in planning. Invite them to support the resident in their chosen leisure and social activities.

See the [Printable Resources](#) for a fact sheet to give to families.

Using the Pain Care Goal Plans

Pain Care Goal Plans promotes a person-centred approach, focusing on ‘what matters’ for the resident, rather than ‘what is the matter’ with them. The template encourages residents to identify what they want to achieve from their pain treatment plan. Staff can assist residents to formulate goals that are achievable, individualised and person-centred, and provide support. For goals that are achievable and realistic, staff must consider residents’ health factors (e.g. severity of illness and diseases).

There are five elements to the Pain Care Goal Plan:

1. **Goals:** Ask the resident what they want to achieve from pain management. These may be general (e.g. to feel comfortable most of the time) or specific (e.g. to be able to move without pain in order to participate in the gardening program).
2. **Achievable goals** (skip this step if the goals identified by the resident are already realistic and attainable): Some goals expressed by residents and family may not seem achievable by the care team. If so, staff can re-examine their own practice, to re-address both their own and the resident’s expectations and to collaborate on formulating achievable goals. E.g. if a resident wants complete elimination of their pain while beginning an exercise program, and this seems unachievable to the care team due to the severity of the resident’s health condition, staff should work with the resident to formulate a strategy. In this case, the strategy may be to break up the goal into smaller steps.
3. **Actions or treatments** (be specific): List actions or treatments to put in place to achieve goals. This includes specific therapies (non-pharmacological and pharmacological). Details of the actions/therapies should be planned with the resident and noted (e.g. the resident will attend a physical therapy session for an hour once a week to strengthen muscles).

Also specify the support available and quantify the actions (e.g. the PCA will provide encouragement and escort the resident for a walk each day).

4. **Timeframe:** Specify a time period for goals to be achieved. This will make it more likely that actions will be taken towards meeting goals. If some goals need to be actioned on an ongoing basis, note this and ensure evaluation and reassessment is also planned on an ongoing basis.
5. **Evaluation and date:** Review progress towards meeting the resident’s pain care goal plan on a regular basis, as appropriate. This can be done as part of their existing planned pain assessments.

Who should talk to the resident about their pain management goals and complete the pain care goal plan?

The multidisciplinary care team should work with the resident to complete the pain care goal plan. Depending on the goals identified, certain members of the team should be consulted. Whichever staff member completes the goal plan with the resident should communicate information with the rest of the team to support what the resident has identified as important to them.

How should a discussion take place about the pain care goal plan?

Talking with residents and families should be exploratory rather than interrogational. It is a collaborative process and may require flexibility and creativity. You may need to reframe the discussion to help the resident express their goals if they have difficulty. You may rephrase questions, for example to ‘what is important to you?’ and ‘what things would you like to do through reducing or eliminating your pain?’. Once what the resident has expressed has been translated into achievable goals, an individualised action plan can be created collaboratively.

See [Printable Resources](#) for a copy.

Using the Pain Care Goal Plans

How to make sure goals are achievable?

Residents' goals should be action-oriented. Some people may have broad or unrealistic goals. The **SMART** strategy may be useful:

SMART Goal Strategy

Specific: Target a specific care approach for improvement of pain. Be specific so that the goal is individualised for the resident.

Measurable: How will we know when the goal is achieved? Staff should quantify or at least suggest an indicator of progress.

Achievable: What results can be realistically achieved given available resources? Collaboration and advice from other staff may be necessary (e.g. from the GP). Any barriers and solutions can be identified at this stage.

Relevant: The goal must be important to the resident, and any actions must take into account their wants and needs.

Time limited: Specify when the results can be achieved, and follow up at the specified time period.

Advanced topic: Goal Attainment Scaling (GAS)

The Pain Goal Plan is a simplified version of the Goal Attainment Scaling tool (GAS). GAS is a comprehensive and widely used tool for goal planning. The strength of GAS is that it quantifies the extent that a person's goals are being met. GAS is free to use but does require some training.

Follow this link for more information: <https://www.sralab.org/rehabilitation-measures/goal-attainment-scale>

Pain management approaches for people living with dementia

Simple techniques such as redirection, distraction, social interaction, reminiscence, music and pet therapy, balance between rest and activity, and comfort can be tailored to suit each individual in consult with family and others who can inform staff of residents' personal likes, dislikes and previous leisure and activity patterns. Transfers, toileting, showering, repositioning and other procedures may need to be assessed and modified to mitigate provoking pain.³⁶

Intervene is a workbook and guide produced by HammondCare as an educational intervention for aged care staff to provide a person-centred pain management plan for people living with dementia. This resource contains multiple case studies demonstrating how pain can be managed in different ways based on the individual needs of people living with dementia.

Follow this link for the resource: <https://www.dementiacentre.com/images/PDFs/HC-5-Steps-Flip-Book.pdf>

³⁶ Refer to Chapter 7 of *Pain in RACF 2nd Ed* for comprehensive information on pain management for people living with dementia.

Selecting the right pain treatment

Pain treatments range from psychological and educational approaches, movement and physical activity, complementary and integrative medicines, and pharmacological treatments.

Pain treatments are divided broadly into non-pharmacological, pharmacological or interventional approaches. Interventional approaches often involve surgery and will not be covered further here³⁷. Non-pharmacological approaches include education and setting achievable goals, addressing postural and comfortable positioning, exercise and activities, sleep and psychological therapies. Pharmacological approaches use medications for treatment. A multidisciplinary approach that incorporates both the non-pharmacological and pharmacological is often needed for chronic pain.

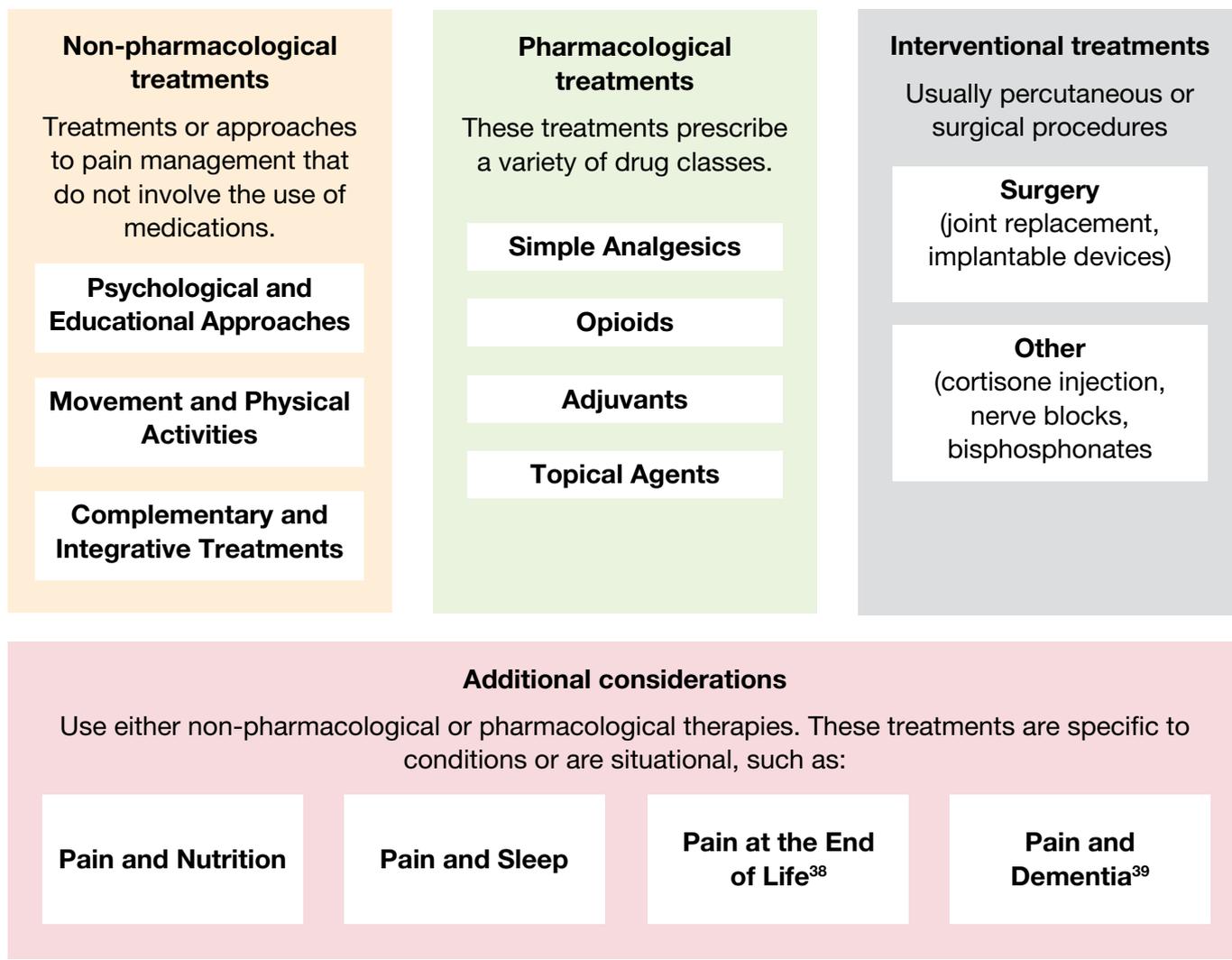


Figure 10: Summary of pain treatment options

³⁷ Refer to “Interventional approaches in the management of severe disabling pain” in Chapter 6 of *Pain in RACF 2nd Ed.*

³⁸ Refer to Chapter 8 of *Pain in RACF 2nd Ed* for more comprehensive information about pain and dementia.

³⁹ Refer to Chapter 7 of *Pain in RACF 2nd Ed* for more comprehensive information about pain and dementia.

Non-pharmacological approaches

The following non-pharmacological pain treatments are briefly discussed, with links to comprehensive sections in the *Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition*:

- Psychological and educational approaches
- Movement and physical activity
- Nutrition
- Sleep
- Complementary and integrative medicine (CIM)

Pain management is most effective when non-pharmacological and pharmacological approaches are combined. In some cases, non-pharmacological approaches can be used without pharmacological approaches to manage pain. Non-pharmacological interventions should also be maximised for residents living with dementia.

Psychological and educational approaches

Pain is a sensory and emotional experience: the mind is always involved. And psychological factors including stress, anxiety, depression or fear can make the experience of pain worse. Psychological and educational approaches are essential for managing persistent pain and should be tailored to each resident's cognitive capacity.⁴⁰ As outlined in the section on the bio-psycho-social model, psychological aspects (such as mood, personality, behaviour) have a role in the development, continuation and impact of pain. Understanding the bio-psycho-social context of a person's pain experience and its impact on their life using a person-centred care approach will help in developing the best treatment plan.

Psychological approaches can turn down the volume on pain.

The experience of pain can be turned up or down like a volume dial on a radio. The pain signals may be still there, but factors like stress can turn up the volume and psychological treatments like relaxation or distraction can turn it down.

Residents and families may have fears about pain and its treatment. So they need to be informed about the pain management plan and offered education about pain. For example, an area of concern may be addiction to analgesics or that side-effects are unmanageable and should be used sparingly. Other misconceptions include thinking that pain should be tolerated or is inevitable. Education can help reduce these fears and misconceptions⁴¹. Residents in pain may want to avoid physical activity in order to avoid pain, unaware that physical activity can help both maintain function and reduce pain. When educating residents and families about physical activity, discuss the benefits of physical activity and exercise rather than focus on the risks of physical inactivity. Residents and families may also be unfamiliar with the bio-psycho-social model. Many residents would have grown up with the medical model of pain, and feel that medications are the only option. Residents and families need education to understand the bio-psycho-social approach and require ongoing encouragement to adopt these principles.

How others can help with psychological interventions

Important to psychological interventions is working with a resident's support system. Family members and carers can present both opportunities and challenges for managing pain. Involving family members and other important people can help to provide valuable insights into the resident's behaviour and cognition. These people can also promote educational messages, help residents master and practise new skills and encourage healthy behaviours. It can be helpful to ask family members/carers for details about the resident's routines, likes and dislikes, previous coping styles, and personal stories to aid in psychological interventions. See [Printable Resources](#) for resources that can be provided to family members and other carers.

⁴⁰ Refer to Chapter 3 of *Pain in RACF 2nd Ed* for more information about psychological and educational approaches to managing pain.

⁴¹ Refer to Chapter 10 of *Pain in RACF 2nd Ed* for more information about the role of pain education in more detail.

Psychological and educational approaches to pain management

Educational Approaches	Educational approaches teach residents and families about pain and its impact, and can inform them on how to manage pain. Education is important for all, but some residents will also need psychological treatment approaches to ease their pain experience. See also 'Unhelpful ways of thinking about pain'.
Psychological Approaches	Psychological treatment approaches can assist residents to change how they think, act and feel that is unhelpful for managing their pain. There are two broad categories: self-directed (or with aged care staff assistance) and health professional assisted (such as a psychologist).
Self-directed or staff assisted	Creative activities help residents cope better with their pain and improve their quality of life. Examples include: craft, singing, music, and gardening. All staff, including PCAs and lifestyle staff, can help to encourage residents with creative pursuits. These activities should be considered as “therapies of clinical benefit” for residents. Suitably trained staff (i.e. lifestyle staff) can oversee the structure of these programs. ⁴²
	Mental distraction is shifting your attention away from pain by focusing on something else. See https://www.aci.health.nsw.gov.au/chronic-pain/painbytes/pain-and-mind-body-connection/how-can-distraction-be-used-to-manage-pain
	Emotion regulation is controlling or reducing the intensity of negative emotions. There are a number of techniques that can be self-taught or with the assistance of a health professional. See https://positivepsychology.com/emotion-regulation/
Self-directed or staff assisted	Positive/guided imagery uses mental images of pleasant sights, smells, sounds, tastes etc. to create a positive mental and emotional state.
	Mind-body approaches , such as relaxation and mindfulness meditation can help people become aware of and accept their experiences. See section on mindfulness meditation for more information.
Self-directed or staff assisted	Acceptance Commitment Therapy (ACT) or Cognitive Behavioural Therapy (CBT) can reduce the effect of pain on residents' lives through teaching them how they may think in a different way, impacting on their behaviour and emotions. A clinical psychologist can help in pain management by implementing CBT or ACT.

⁴² Refer to Chapter 3 of *Pain in RACF 2nd Ed* for more information on creative activities for pain management.

Unhelpful ways of thinking about pain

It helps to listen to the resident and observe if they may be thinking about their pain in unhelpful ways. Two examples of unhelpful thinking are:

Catastrophising

is when a resident focuses deeply on pain, magnifies its severity, or feels helpless about it. This exaggerated way of thinking increases pain levels, disability and depression.

Fear avoidance

is an excessive and debilitating fear of moving or activity. The inactivity that comes from this fear creates a cycle of deconditioning, disability and low mood.

Listen carefully when residents express these thoughts about their pain, as this is an opportunity for staff to gently encourage residents to adopt more helpful thought patterns. Begin by acknowledging the resident's distress. Reassure

the resident and respond appropriately to unhelpful thoughts⁴³.

Mindfulness meditation

Mind-body approaches, such as mindfulness meditation, help people to become aware of and accept their experiences (both emotional and physical). With regular practice, this can reduce the sensitivity of the nervous system and pain-related distress. Mindfulness meditation helps people develop a purposeful attention to the present moment, 'tuning in' to any sensations, thoughts and emotions without judgement or reaction. Mindfulness works best with residents who can follow simple instructions and are willing to try new techniques. It can be especially effective for residents with cognitive impairment (such as early stage dementia), those who might not suit a structured psychological treatment like CBT, and for those where meditation is a part of their spiritual or culture practice. Sessions should be short in duration for older people (e.g. 5-10 minutes).⁴⁴

Movement and physical activity

Physical activity benefits residents in many ways. It slows physical and cognitive deterioration, is a distraction from the pain itself, helps develop positive active coping strategies, improves mood, and encourages socialising with others. The way in which a resident is moved (manual handling) requires careful planning and is also explained in this section. Regular physical activity should be assessed and planned by a qualified health professional. The general principles for helping residents with pain to participate in physical activity safely include⁴⁵:

It's enjoyable

Make sure the activity is enjoyable and meaningful for the resident. This is part of person-centred care.

Pace and grade activities

Gradually increase activity in stages to avoid pain flare-ups and build the resident's confidence.

Modify activities

Adapt the activity to fit the resident, e.g. break-up activity into smaller parts, use assistive devices and props.

Manage flare-ups

Flare-ups are normal. Manage them by reassuring the resident, using distraction, avoiding excessing rest, and using medications.

Adapt treatments to the environment

Consider the environment, e.g. music, reduced light/noise and accessing green space.

⁴³ Refer to Chapter 3 of *Pain in RACF 2nd Ed* for practical examples of responding to unhelpful thoughts.

⁴⁴ Refer to "Meditation and Mindfulness" in Chapter 5 of *Pain in RACF 2nd Ed* for more information on particular meditation and mindfulness techniques, and tips to adapt them for aged care. Also see the Printable Resources for psychological approaches to managing persistent pain.

⁴⁵ Refer to "Moving with Pain" in Chapter 4 of *Pain in RACF 2nd Ed* for comprehensive information on how to conduct physical activity safely. See also Table 12 from the same chapter for ways to improve physical activity levels of residents in aged care facilities.

Movement, Exercise and Physical Activity⁴⁶

Active Approaches – Exercise

Programs that focus on aerobic exercise, strength and training with resistance and balance training have the most impact for pain management.

Aerobic exercise

Sustained, repetitive movements of large muscle groups with more activity than normal, e.g. walking, water aerobics

Balance exercise

Improving balance through exercises. e.g. reducing the base of support, moving the centre of gravity, or reducing the need for upper limb support.

Strengthening exercise

Includes weight bearing (working on your feet) and resistance (where a load is added) e.g. mini knee bends (mini squats), heel raises, and bicep curls.

Multimodal exercise

A combination of each exercise type may be best for residents in pain. Exercise should be ongoing and should progress with guidance from a physiotherapist or exercise physiologist.

Active Approaches – Physical Activity

When formal exercise programs are not suitable, physical activity is important.

Unstructured movement

For some residents, it may be more realistic to promote non-sedentary behaviours than formal exercise programs (e.g. encouraging them not to sit for long periods of time).

Playful tasks (seated or standing)

Purposive play activities that are fun and/or social (e.g. Nintendo Wii, dancing, 'seated' lawn bowls)

Hobbies and recreational activities

Activities that incorporate physical activity (e.g. gardening)

Passive Physical Treatments⁴⁷

These treatments are non-invasive. Not much evidence they work, and sometimes have risks.

Superficial heat or cold

(e.g. heat packs, superficial cold)

TENS

(Transcutaneous Electrical Nerve Stimulation)

Other considerations

Dealing with muscle pain

Movement and contractures

Transfers and manual handling

Figure 11: Summary of movement, exercise and physical activity options.

⁴⁶ Refer to Chapter 4 of *Pain in RACF 2nd Ed* for more information about exercise and physical activity.

⁴⁷ Refer to Chapter 4 of *Pain in RACF 2nd Ed* for more information about physical treatments.

Dealing with muscle pain⁴⁸

- Muscle pain is normal after physical activity – reassure residents that it is normal and will pass
- Initially, increasing activity may cause pain to worsen.

But this will improve as activity becomes more regular

- Consider offering analgesia 20 minutes prior to exercise

Exercise and physical therapy for people living with dementia

Physical therapy can greatly benefit people living with dementia who have pain. Generally, residents with dementia are less engaged in physical activity than those without dementia. It is important to try to engage residents with dementia in exercise programs. Staff should design enjoyable programs based on the resident's past interests, such as gardening, walks outside or exercising in water.

Movement and contractures

Not moving is a major cause of contractures. Prevention through regular movement is important. Existing or suspected developing contractures should be assessed by a suitable health practitioner (e.g. a physiotherapist, exercise physiologist, occupational therapist or GP).

Joint contracture is a painful and debilitating condition in which stiffness in the joints and connective tissues restricts normal movement. Contractures are particularly problematic and painful during personal care and when residents are repositioned. Care staff need to be trained in how to move residents with contractures correctly⁴⁹. Contractures are commonly seen in progressive neurodegenerative disease, some dementias, Parkinson's disease and related disorders and strokes.

Passive physical treatments

Heat and Transcutaneous Electrical Nerve Simulation (TENS) can reduce the intensity of pain in the short term. They must only be used for residents who are able to communicate about their experience, otherwise there is a risk of tissue damage and/or further discomfort. They may also make pain worse for those with sensitive skin.

- Heat packs should not be applied within 48 hours of pain developing, as they may increase swelling
- Superficial cold should not be used for treating pain in aged care residents, as it can cause tissue damage and discomfort, and there is limited evidence for its effectiveness
- TENS may be useful for some kinds of persistent pain, like osteoarthritis and post herpetic neuralgia. For pain relief, residents should feel a noticeably strong but comfortable tingling sensation. Excessive levels are uncomfortable and can be painful. TENS is best used for 20 minutes followed by a rest period of an hour and then set to a 'pulsed' or 'ramped' setting, which constantly changes the input to the skin

Transfers and manual handling

Many residents need help moving from one position to another. A resident who cannot move independently is particularly vulnerable to pain, due to prolonged periods of immobility. They may also experience stress being moved by someone else. The two main reasons why manual handling may worsen pain are that the resident may have either heightened pain sensitivity (hyperalgesia or allodynia), resulting from a persistent pain condition, or a decreased range of movement and manual handling. Staff need to be careful not to exceed the resident's normal range of movement too quickly. Care

⁴⁸ Adapted from Tip in Chapter 4 of *Pain in RACF 2nd Ed.*

⁴⁹ Refer to "Managing contractures" in Chapter 4 of *Pain in RACF 2nd Ed* for further advice.

staff can help to modify residents' range of movement with active or passive stretching, but must be trained by a suitably qualified health care professional such as a physiotherapist.⁵⁰

Staff who move residents can reduce the risk of worsening pain by keeping the following in mind:

Points to keep in mind when manual handling

- Allow additional time to plan and execute the manoeuvre. This will help the resident to feel safe, in turn preventing protective muscle tension and stiffness which can cause pain
- Plan the transfer with the resident (if able) first. Feeling out of control can escalate fear and pain
- Consider breaking the transfer up into several "chunked" movements which can be discussed during the planning phase. This may foster a greater feeling of control
- Clearly communicate to the resident both what you will do and what their role is in the transfer
- Encourage as much of the resident's active participation as possible. In the case of mental health decline, strategies described earlier, such as understanding their motivation and play, may help to involve the resident
- Warm up the joints first (actively if possible) by encouraging movement in the resident's current position i.e. weight shifting from left to right, knee straightening and bending, drawing pelvic circles
- Note the resident's sensitive areas and avoid direct contact
- Gentle support in areas above or below the painful area(s) may help during the transfer

- Once a helpful strategy has been found for an individual resident, this may be added to their care plan and taught to other staff. Provide a clear protocol in the care plan and use senior care staff to assist when residents have complex needs and problematic transfers.
- Ensure the care plan is individually synchronised with the resident's sleep and medication schedule to maximise their comfort

Complementary and integrative medicine (CIM) approaches

CIM approaches are increasingly popular and residents have a right to access them. Health professionals need to be open and aware of complementary and integrative approaches and how they may interact with or support conventional medical care.

Before a resident starts CIM, it is important to consider what else they have tried to manage their pain, what the risks and benefits of the CIM may be, if there is evidence for its effectiveness, and if it is affordable for the resident. When the resident is already using CIM, additionally assess any side effects, why they have decided to use the CIM, and what their experience has been.

⁵⁰ Refer to "Transfers and manual handling" in Chapter 4 of *Pain in RACF 2nd Ed.*

Some examples of complementary approaches that can be used for pain management include the following core (active) mind and body approaches⁵¹:

Tai Chi

Typically includes a sequence of slow, controlled movements, concentration and gentle breathing

Tai Chi programs should be modified to suit individual capability. For example, it can be practiced seated or in bed

Yoga

Involves different postures, breathing exercises, deep relaxation and meditation.

Yoga should be tailored to suit the individual, for example, by modifying poses to seated yoga, bed stretching yoga, eye yoga, postural yoga and breathing practices

Meditation/mindfulness

Involves kind and focused attention on relevant aspects of one's experience, without judgement

Mindfulness practices can be modified for aged care residents. This may involve adapting for sensory, cognitive and postural/seating issues. Strategies such as repetition and learning aids may assist.

Guided imagery

Uses visualization and imagination to resemble objects or events. It can be done with CD's, apps, podcasts or online streaming services

Music therapy

An art form of expression involving listening to and/or singing music. Should be tailored to the resident's culture, spirituality and personal choices

Hypnotherapy

Involves inducing a trance like state to promote relaxation and improve suggestibility for treating health and introducing behavioural changes

Deep & controlled breathing exercises

Paced, diaphragm or abdominal breathing

Progressive muscle relaxation

Involves tensing muscles, then releasing the tension in various muscle groups

⁵¹ Refer to Chapter 5 of *Pain in RACF 2nd Ed*

Supplementary (non-active) CIM for pain management⁵²

Aromatherapy

Uses oils with scent for relaxation and healing. The oils can be inhaled or absorbed over the skin by massage or bath

Acupuncture

Traditional Chinese medicine that involves inserting needles into the skin to stimulate areas of the body. Consideration of the resident's cognition is important before applying acupuncture

Massage, spinal manipulation and reflexology

Massage, spinal manipulation, chiropractic, osteopathy and reflexology can offer short-term advantages for health and wellbeing. These should be tailored to the resident and residents must be made aware of any risks involved

Therapeutic touch

Healing touch or reiki focus on transferring energy to the body to promote health. This can provide comfort to the resident

Natural products

Herbal remedies, vitamins, minerals, amino acids, dietary products, glucosamine, probiotics and fish oils can be used as complementary treatments for pain. There is limited evidence for their safety and effectiveness, so care must be taken in giving them to residents

Digital health and New Age therapies

Evolving technologies, such as robots, video gaming systems, virtual reality, electronic devices, apps and other online solutions can promote cognitive, physical and social support

Pet therapy

Animal-assisted therapy (e.g. a therapy dog) may help to reduce emotional distress and pain

Pain and Nutrition

Nutrition is an important factor in pain management. Poor nutrition may promote painful conditions. Likewise, painful conditions may lead to or exacerbate poor nutrition. Good nutrition and the pleasure of enjoyable and nutritious meals in a positive social environment can instead significantly improve quality of life.⁵³

Ensure residents are adequately hydrated and are eating as well as can be expected

Consider factors such as acute or exacerbated periods of pain, oral health or masking of nutrition-related symptoms for residents with other health problems (e.g. symptoms of dehydration including delirium, urinary tract infections, headaches etc. can be mistaken for symptoms of other health problems)

Consider the side effects of pain medications such as opioids and non-steroidal anti-inflammatory drugs (NSAIDs) e.g. constipation and stomach upsets

To stimulate nutritional intake:

- Increase fat, protein and/or flavor content of meals
- Make meals look appetizing and include a variety of colours, odours, flavours and textures
- Offer smaller portion sizes often
- Serve liquids between meals rather than excessive amounts with meals
- Offer a small amount of alcohol to stimulate appetite where appropriate (not for those at risk of falls or those taking certain medications, and evaluate risks and benefits)

⁵² Refer to Chapter 5 of *Pain in RACF 2nd Ed*

⁵³ Refer to Chapter 9 of *RACF 2nd Ed* for more information about pain and nutrition.

Avoiding dehydration: Dehydration can increase sensitivity to pain. Older people may not drink enough fluid due to pain, dementia, not having independent access to fluids or if they are concerned about managing continence. Signs of dehydration include thirst, dry mouth, increased heart rate, low blood pressure, dark urine, reduced urine output, or fatigue.

A goal of 700-800 ml of liquid per day is realistic. To reduce the risk of dehydration:

- Offer choice of beverages that are visible and accessible
- Assist with eating and drinking if needed
- Offer food with high water content
- Offer small amounts frequently

Diarrhoea can be a side effect of broad spectrum antibiotics, or can be caused by dietary factors. It is a risk factor for malnutrition and dehydration. If diarrhoea is unrelated to antibiotics, assess the resident's diet history, including supplements to determine the cause. Treat any dehydration appropriately. Check with a dietician for the best recommendations for each resident

Constipation can be caused by inadequate nutrition and/or hydration and as an adverse effect of medication. It can lead to discomfort, anxiety, more pain, headaches and can further impede appetite and the enjoyment of meals. Options for treating constipation include:

- Ensuring adequate fluid intake
- Increase intake of foods rich in fibre
- Consider dietary supplements e.g. psyllium husks
- Consider use of laxatives

Assessing nutritional status and risk of malnutrition⁵⁴

Malnutrition is when a person has too many or too few nutrients for their needs, causing adverse effects on the body, the function of organs and health outcomes. It is common in aged care and is associated with poor quality of life and premature death.

Here are two tools that assess nutritional status and identify residents who are malnourished or at risk. Conduct either the SGA or MNA-SF for all residents on admission, with regular monitoring afterward.

Subjective Global Assessment (SGA)⁵⁵

- Assesses recent food/fluid intake, weight changes, wasting of muscle and fat, gastrointestinal symptoms, and other reasons for low nutritional intake
- Enables staff to determine which individuals may benefit from nutrition care.
- Can be used with different populations of people.
- 10 minutes to administer
- Use SGA on **resident admission** and re-assess resident **every month**.
- See the Printable Resources for the [SGA tool](#) and [tips on its usage](#).

⁵⁴ Refer to Chapter 9 of *Pain in RACF 2nd Ed* for more information about nutritional assessment.

⁵⁵ Refer to <http://www.subjectiveglobalassessment.com> for additional information about the SGA.

Mini-Nutritional Assessment (MNA)⁵⁶

- Assesses decline in food intake and cause, mobility status, involuntary weight loss, psychological distress or acute disease, neuropsychological conditions, BMI (or calf circumference if BMI unavailable)
- For older adults and makes recommendations for intervention based on each individual's status.
- There are two versions, the short form (MNA-SF) and the full form (MNA).
- MNA-SF requires no special training and does not have to be completed by a health care professional. 5 minutes to administer.
- If MNA-SF <12 points, then complete a full MNA to help identify the cause of poor nutritional state.
- The full form MNA is easily administered by a health care professional (or other staff with thorough training). 10-15 minutes to administer.
- Use MNA-SF on resident admission and re-assess resident every 3 months.
- See Printable Resources for the [MNA-SF tool](#) and [tips on its usage](#).

Pain and sleep

Pain affects sleep and poor sleep can make the pain experience worse.⁵⁷ People with chronic pain commonly report sleep that is disturbed, of poorer quality, and results in worse daytime functioning. Sedatives are often used, but they are not always effective and may have significant risks (they may stop working as tolerance builds and they may contribute to confusion and falls). Sleep medications should be discussed with the pharmacist and GP.

Care staff can support residents with their sleep. You can discuss the tips with the resident.⁵⁷ You can also do the following:

- Ensure that all sleep requirements are added to the care plan
- Structure night staff routine to ensure that residents are not disturbed unnecessarily
- If residents wake, offer comfort and support, a warm drink and some breathing exercises to help settle back down
- For residents who have behavioural problems at night, check pain medication management and other causes with the multidisciplinary team.

Pharmacological treatments

A simple physical or medical approach to severe, long-lasting chronic pain often does not work.

Always consider combining non-pharmacological options when using medications. These are outlined in the non-pharmacological treatments section of the toolkit. There are risks associated with analgesics and adjuvants in the older person, but these can be managed.

Pharmacological treatments should be considered at best as a partial response to persistent pain.

The resident's medical practitioner or GP has the lead clinical role and responsibility in medications, but relies on accurate assessment and reporting from nursing and care staff, particularly with residents who are unable to recall or report their pain when the GP visits. Pain history, pain assessment, non-pharmacological strategies and their outcomes should be documented by the RN and communicated to the GP.

Before initiating or escalating pain medication, GPs (or other prescribers) need to consider optimal care, risks against benefits, information and the perspective of the care team, including the resident (when possible) and their family.^{58, 59}

⁵⁶ Refer to <https://www.mna-elderly.com> for additional information about the MNA.

⁵⁷ Refer to Chapter 3 of *Pain in RACF 2nd Ed* and the Printable Resource, "Tips for Sleep".

⁵⁸ Refer to Chapter 6 of *Pain in RACF 2nd Ed* for more information on common pain medications used in residential aged care.

⁵⁹ Other resources include the RACGP aged care clinical guide (Silver Book) section on pain: <https://www.racgp.org.au/getattachment/3c65dca2-b451-4139-ade4-36fef8bf0dd4/Pain.aspx>

In summary, when using pharmacological treatments:

- Start low, go slow
- Less is more in the elderly
- Opioid dose is related to age
- Keep analgesia simple but multimodal

Other key points include:

- Responses to medication may vary from resident to resident and depends on health conditions. GPs should trial and reassess analgesia and side effects and change medication strategies if necessary. Failure with one medication does not mean another medication of the same class won't be successful.
- How we respond to drugs changes as we get older. As we age, physiological changes in the body affects the absorption, distribution, metabolism and elimination of medications. For residents in aged care, the effect of a pain medication may be greatly reduced or enhanced. Likewise, the side-effects of medications may be more pronounced.

- When pain is persistent, use “around-the-clock” medication administration.
- When “incident” pain or pain flares can be predicted (e.g. wound dressing, transport, desited activity) then pre-emptive analgesia can be used. e.g. 30 minutes before the incident or activity.
- Topical treatments can be considered.
- Opioids can be added in combination with partially effective first and second line pharmacological treatment. Use of high doses of opioids can over long periods of time can also cause increased in pain sensitivity or opioid induced hyperalgesia.
- The facility should ensure a clear policy for regularly monitoring and assessing pain, once pain medications are commenced. This requires oversight and review by senior nursing staff. A clear process for escalation to medical review and escalated allied health involvement should be highlighted in staff procedures. See Step 4: Monitoring and Evaluation for more details.

Type of pain	Suggested treatment
Chronic nociceptive pain	Non-pharmacological strategies are the preferred option. Opioids are less effective for chronic nociceptive pain and need careful management.
Mild acute nociceptive pain	Short term, low dose non-steroidal anti-inflammatory drugs (NSAIDs) can be used with caution. If simple analgesia proves inadequate, then consider a trial of adjuvant medication
Chronic neuropathic pain	Consider the role of antidepressant and antiepileptic adjuvant drugs (for example post-shingles, osteoarthritis and sensitisation, cancer pain).
Moderate-to-severe nociceptive pain and neuropathic pain	Consider multimodal analgesia using paracetamol, an NSAID, and an opioid. But monitor side-effects and manage carefully.

Medication for chronic pain

There are a range of medications appropriate for pain management in older people. All staff (e.g. registered and enrolled nurses) responsible for medication administration must be knowledgeable about medications used for managing pain. Information about pain medications should also be available to all staff, including care workers. Nurses in clinical

leadership roles need to inform themselves of their responsibility and accountability when preparing and guiding other workers who are administering medications.⁶⁰

Aged care staff and health professionals can refer to Fact Sheet 5, and care workers can refer to Fact Sheet 4 in the Printable Resources for information about pharmacological approaches to pain management.

⁶⁰ Refer to Chapter 6 in *Pain in RACF 2nd Ed* for a comprehensive discussion about pain medication.

Common medications

Brief descriptions of medications used for pain are below.⁶¹

Paracetamol

- Acts as an analgesic and lowers temperature but is not anti-inflammatory.
- Can be beneficial for residents with musculoskeletal pain, osteoarthritis of the hip and knee, and lower back pain. A lack of evidence exists for chronic lower back pain or neuropathic pain.
- Generally well-tolerated. Avoid exceeding 4g per day in divided doses.

Non-steroidal anti-inflammatory drugs (NSAIDs)

- Most commonly prescribed for osteoarthritis and back pain, and for other acute inflammation.
- Two broad classes of NSAIDs: selective and non-selective. Selective NSAIDs range from COX inhibitors that inhibit synthesis of prostaglandins with varying selectivity (e.g. celecoxib, etoricoxib), relative selectives (e.g. meloxicam) and non-selectives (e.g. ibuprofen, diclofenac, naproxen, indomethacin and aspirin).
- Can cause gastrointestinal, cardiovascular and renal adverse effects – use with extreme caution as harm increases with dose and duration, and only when benefits outweigh risks.
- All staff should be alert for evidence of gastrointestinal bleeding, abdominal pain, dark stools, signs of impaired renal function including change in urine output, oedema and fatigue.

Opioids

- Used for acute nociceptive pain, surgical, cancer and chronic non-cancer pain (though opioids for chronic non-cancer pain has become increasingly questioned over recent years). Opioids are less useful for chronic neuropathic pain.
- Recommended for malignant cancer and end of life pain management.

- Opioids can be classified as: atypical (e.g. tramadol, tapentadol), weak (e.g. codeine and low dose buprenorphine), or strong (e.g. oxycodone, morphine, hydromorphone, fentanyl, and high dose buprenorphine).
- Older people are more susceptible to side effects including: constipation, respiratory, depression, falls, nausea, worsening sleep apnoea, hypotension, osteoporosis, sedation, dizziness, fracture, depression, delirium, opioid induced hyperalgesia and immunosuppression. All staff should be alert to these side effects and report appropriately.
- ‘Start low, go slow’ to reduce side effects – use as little opioid as possible for the shortest duration
- Time-limited opioid use can provide pain relief while establishing non-pharmacological therapies for treating pain long-term
- Opioid conversion charts should be available at the point of prescription at the nurses’ station and should also accompany medication charts.

Adjuvant analgesics

- May reduce pain sensitisation in nociceptive pain
- Antidepressant and anti-epileptic medications can be useful for treating pain in diabetic neuropathy and post-herpetic neuralgia
- Tricyclic anti-depressants can produce side effects including dry mouth, postural hypotension, constipation, urinary retention, cognitive impairment and sedation
- SSRIs and mirtazapine are better tolerated by older people than TCAs

Topical agents

- Creams and patches that can be applied externally can help with some types of pain (e.g. peripheral neuropathic pain or osteoarthritis of the knee or hand)
- These agents may cause skin irritation, so use with caution and monitor effects
- Topical NSAIDs can also be effective for peripheral arthritic joint pain

⁶¹ Refer to Chapter 6 in *Pain in RACF 2nd Ed* for comprehensive information about each of these pain medication classes, how they work, when to use them, how to prescribe them, side effects, and other considerations.

Clinical concerns and medications

Pain medications increase the risk of unwanted side effects, especially:

- **Falls** risk is increased by anti-hypertensives, antidepressants, psychotropics, opioids and polypharmacy.
- **Cognitive dysfunction** is affected by opioids, anticholinergics, anti-neuropathic medication, and by poorly controlled pain and polypharmacy.
- **Constipation** is a common problem with opioids.
- **Polypharmacy** is typically defined taking multiple medications. A complex pain medication regime will likely increase pill load.

Balancing between possible unwanted side effects and the benefit of analgesia requires an informative discussion with the resident and family before commencing medication. Personal care staff led by senior nurses need to be aware when residents start newly introduced medication. Staff must be alert for changes in function, mood, behaviour and appetite as they monitor the efficacy of new medications, using validated pain assessment and charting tools.⁶²

Bowel regimen for constipation

Constipation is commonly associated with immobility and/or decreased fluid and fibre intake for older residents. Medical conditions and medications can contribute. Residents need to be systematically assessed to avoid constipation through recording of bowel movements, and their medications need to be optimised with regard to their bowel function.

For more information about managing constipation, refer to the Printable Resources.

Analgesics at end of life

Palliative care aims to improve comfort and function and address the psychological, spiritual

and social needs of residents with life limiting and irreversible illness, whilst respecting autonomy, dignity and choice.⁶³ Advance Care Planning is an important process to ensure this by promoting conversations and documentation in a safe and sensitive manner to guide end of life care.

End of life care is focused on relief of pain and suffering in the last days or weeks of life. Anticipatory prescribing and access to medication that may be needed to relieve pain and suffering at the end of life is key.⁶⁴

Bereavement and grief support

Care staff often have long standing and close relationships with residents and their families in comparison to many other health care sector workers. There is a significant emotional toll in witnessing frequent deaths particularly if staff do not feel they have provided optimal peace, comfort and dignity. Often at residents' end of life, staff become increasingly involved with soon-to-be bereaved families. Palliative Care Services can assist and refer families and staff to ongoing bereavement and grief support services.

Assistance can be sought through:

- Referral to local palliative care service
- Contact Advance Care Planning advisory line: <https://www.advancecareplanning.org.au/about-us/contact-us->
- The Australian Centre for Grief and Bereavement: https://www.grief.org.au/ACGB/Bereavement_Support/ACGB/Bereavement_Support/Bereavement_Support.aspx?hkey=6d7b78f6-7d1b-408e-abe0-b417d5be15bf
- Palliative Care Australia service directory <https://palliativecare.org.au/directory-of-services>

⁶² Refer to Chapter 6 of *Pain in RACF 2nd Ed* for more information about clinical concerns and medications.

⁶³ Refer to Chapter 8 of *Pain in RACF 2nd Ed* for comprehensive information about analgesia at the end of life when to use them, how to prescribe them, side effects, and other considerations.

⁶⁴ Refer to the Printable Resources included with *Pain in RACF 2nd Ed* for a summary of key points for analgesic management at the end of life and opioid use.

Rapidly escalating opioid requirements typically signify that something serious is being overlooked

Consider:

- The suspected mechanism of the pain
- If the medication is being given or absorbed properly
- Whether it may be appropriate to investigate and treat medical problems that may be causing the pain, such as hypercalcaemia, or spinal cord compression
- Treatment usually requires a short hospitalization and this needs to be considered in line with the resident's goals of care and prognosis
- Pain not responsive to opioids. Severe neuropathic pain usually responds best to a combination of non-opioid adjuvant with an opioid. Palliative medicine specialists can advise on prescribing
- Is regional or spinal anesthesia warranted?
- Central sensitisation – specialist input recommended
- Severe psychological distress may be expressed as physical pain

It is critical to seek early help from specialist palliative care teams when these symptoms occur.

Assisted dying vs palliative care

Palliative care practice is distinguished from assisted dying or euthanasia. Unrelieved pain and distress is a palliative care emergency that should trigger referral to specialist palliative care for review and consideration of palliative or terminal sedation. This can only be provided as last resort and if deemed ethically acceptable to the resident, their family and health care providers. This is not euthanasia as the intent is not to cause death. Similarly, withdrawing or not initiating inappropriate or futile treatment is not euthanasia.

Euthanasia in the Australian context is termed Voluntary Assisted Dying (VAD), which means the person must request VAD and have the capacity to understand the implications. More information about VAD and the states in which it is legal can be found at: <https://www.eldac.com.au/tabid/5757/Default.aspx>

Case studies: pain treatment

Case study: Mario

During the meeting involving the multi-disciplinary care team, Mario and his children, a comprehensive treatment plan was created.

First, the group discussed and recorded Mario's goals to be achieved through pain treatment using the Pain Care Goal Plan template. His goals included feeling as comfortable as possible, improving sleep, and being able to participate in more activities.

A wide range of treatment options that didn't involve medication were discussed first. The physiotherapist conducted a physical assessment and scheduled a variety of physical therapies, including massage and a combination of strengthening and aerobic exercise.

The lifestyle coordinator arranged an activity plan to support Mario's exercise goals, including scheduled tai chi. Mario had loved to garden before he was admitted to the facility, so the lifestyle coordinator added him to the facility's gardening program.

Options for improving Mario's sleep were also discussed. It was advised that if Mario's pain treatment was successful, then his sleep should also improve. The team discussed a range of options for improving Mario's sleep routine in the meantime, including good sleep habits and adjusting Mario's room. The PCA would help to monitor Mario's sleep and help accordingly.

During the assessment, it was also identified that Mario was experiencing some ongoing mental distress due to his wife's passing. Some psychological treatments including counselling were discussed and planned.

The GP assessed Mario's options for medication. Mario would continue with his prescribed dopamine agonist medication to treat his Parkinson's disease. The GP also prescribed regularly scheduled (ATC) paracetamol to further treat his pain. Mario was also encouraged to share any feedback with the team on how he felt the pain management plan was progressing toward his goals

Case study: Margaret

After Margaret's assessment at the hospital, the GP read through the documents and consulted with the hospital staff. Margaret would receive treatment for her bone metastasis at the hospital, with the facility GP and other staff implementing a more detailed treatment plan for her pain.

Considering the current severity of Margaret's pain, the GP (with advice from the hospital) recommended initial treatment with an opioid (buprenorphine patch). The GP also recommended a range of non-pharmacological interventions. The nurse, GP, physiotherapist and lifestyle coordinator worked with Margaret and Richard to develop a treatment plan.

The treatment plan involved a stepped approach. A physiotherapist developed an exercise program for Margaret. She would also receive weekly massages. The lifestyle coordinator informed Margaret and Richard about a number of programs in the facility that would help Margaret with relaxation, including meditation and music therapy sessions (Margaret had always loved listening to music from her past). Margaret seemed enthusiastic to participate.

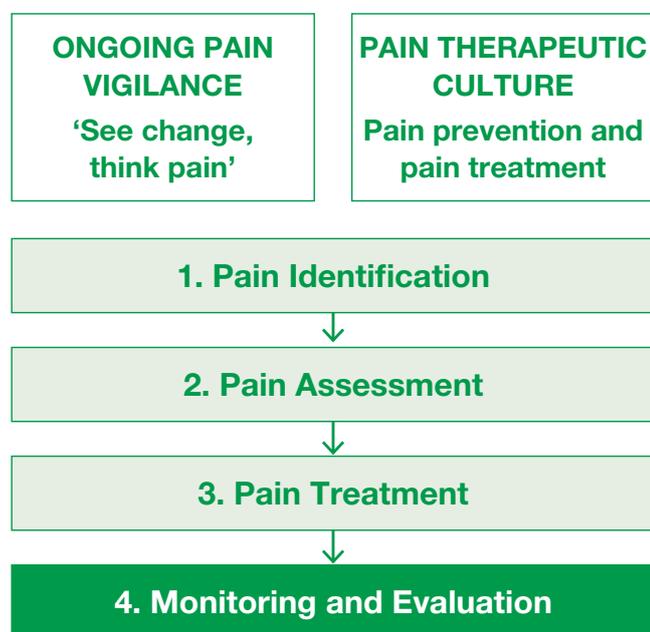
Richard advised that Margaret loved to watch soap opera TV shows, so an instruction was made in her case notes for care workers to ensure that these were playing regularly for Margaret in her room while at rest.

A nutritional assessment was completed and Margaret's dietary plan was tailored based on her needs and in consideration of the opioid medication that she was about to commence.

Richard was provided with education and information about Margaret's pain, and he felt prepared to support her when visiting. He knew how happy it made Margaret to see her children and grandchildren (although she sometimes struggled to remember them), so he arranged regular visits and phone calls with the family. Care staff helped Margaret and Richard hang family photos in her room.

Section D: Pain Management (continued)

Step 4: Monitoring & Evaluation



See this section for:

- Listening to what the resident says about their pain
- Monitoring and evaluating medications

Key summary

- All pain treatments are re-assessed regularly and adjusted as needed to ensure that each resident's pain continues to be adequately managed.
- The facility needs a clear policy for regularly monitoring and assessing pain after any change in treatment, and particularly when pain medications are used.
- Pain assessment scales can be used for monitoring – use that the same scale each time pain is assessed for a resident so that changes can be tracked over time.

Relevant Printable Resources



- [Pain Identification and Assessment Flow Chart](#)
- [Observed pain behaviours that may indicate pain](#)
- [Signs of Pain in Older People](#)
- [Identifying physical pain types](#)
- [The role of care staff in the pain management process](#)
- [Pain in dementia \(identification, assessment, treatment, evaluation and monitoring\)](#)
- [Aged Care Pain Chart template](#)
- [Pain assessment scales](#)

Monitoring and evaluating a resident's response to a pain treatment is an important final step in the pain management process. This step enables all pain treatments to be reassessed and adjusted as needed. It is important to use a systematic and reproducible method when monitoring or assessing pain treatment. For example, nurses should use the same pain assessment scales when monitoring a resident. This allows for comparisons before and after a new treatment to monitor the effect of adjusting a pain treatment plan, to track how a resident's pain is changing, or to understand how a resident's clinical condition is improving or deteriorating over time. For consistent results, it is ideal if same nurse conducts these pain assessments using the same assessment tools each time for each individual resident.

Multidimensional pain assessment scales assess the severity of the pain as well as the impact of pain on function, activity and social interaction. The [Modified Resident's Verbal Brief Pain Inventory \(M-RVBPI\)](#) is an example of a multidimensional scale (see Printable Resources). If a more comprehensive pain assessment such as the M-RVBPI cannot be regularly scheduled, then a uni-dimensional pain assessment scale should be considered.

Though uni-dimensional pain scales (such as the Numerical Rating Scale, Verbal Descriptor Scale, Abbey Pain Scale, etc.) only assess one dimension of pain (typically pain severity), they can be used quickly and regularly to monitor treatment efficacy.^{65, 66}

The facility should ensure a clear policy for regularly monitoring and assessing pain once pain medications are commenced. This requires oversight and review by senior nursing staff. A clear process for escalation to medical review and escalated allied health involvement should be highlighted in staff procedures.

After any change in treatment, the pain needs to be re-evaluated. The pain evaluation doesn't need to be a complete pain assessment, but just a simple measure of how the person is experiencing pain following new/amended treatment. This can also be used as a time to check in with the person about how they are going. Careful monitoring should be conducted. Use a recommended assessment chart. Treating any symptoms that arise when they arise is an important part of the pain management plan.

Pain treatments and their effectiveness for a resident should always be documented in the resident's clinical notes.

Listening to what the resident says about their pain

Give the resident time and opportunity on a regular basis to speak about their concerns about pain. Being mindful of what the resident says and does is also a form of monitoring. Encourage aged care staff to listen to what the resident says about their pain, particularly during casual everyday conversation and not only during routine charting or formal assessment with a GP or nurse). Aged care staff also need to be vigilant for unhelpful ways of thinking about pain, understand that this information is important for the treatment team, and be supported in discussing this with their line managers. Unhelpful ways of thinking about

pain include catastrophising (assuming the worst), rumination (continuously thinking about their pain), and hopelessness (feeling helpless to reduce the pain). Aged care staff need to show that they support the resident, and ideally be trained in simple methods to de-escalate unhelpful talk (see [Printable Resources](#))⁶⁷. Aged care staff need to be given the time to talk ('talk is therapy') and actively listen to residents. Management needs to foster an environment where aged care staff are afforded the time to meaningfully interact with residents.

Monitoring and evaluating medications

To accurately assess a resident's response to a newly prescribed medication or a change in dosing, consider using a suitable assessment tool such as the 24-hour behaviour chart (see [Printable Resources for an example pain chart](#)) or observational pain assessment scales. This is to assess changes in the resident's pain levels and pain experience with new treatment. When pain is more severe, consider more frequent and comprehensive monitoring.

Because many medications have serious side effects for older people, the efficacy, dosage and side effects should be regularly monitored and reviewed. Nursing staff should direct care staff to monitor behaviours and mood after new medications commence or after dose changes. Function, mood, behaviour and appetite may all change when a new medication is commenced. Any clinical concerns that arise following the resident starting a new medication may be the result of medication side effects⁶⁸; therefore, it is important to monitor residents' responses to new medications in terms of alleviating their pain as well as any side effects they may experience. Common changes to look out for include disturbed sleep and/or drowsiness.

⁶⁵ See Appendices from *Pain in RACF 2nd Ed* for these scales.

⁶⁶ See Appendices from *Pain in RACF 2nd Ed* for pain assessment scales.

⁶⁷ Refer to Chapter 5 of *Pain in RACF 2nd Ed* for more details psychological and educational approaches to pain management.

⁶⁸ Refer to Chapter 6 of *Pain in RACF 2nd Ed* for more details about clinical concerns with pain medications in older residents.

Increased risk of:	Potentially associated medications
Falls	Antihypertensives, antidepressants, psychotropic medications and opioids increase risk of falls
Cognitive dysfunction	Opioids, anticholinergics and anti-neuropathic medications can affect cognitive function, especially in people living with dementia
Constipation	Opioids

Polypharmacy (taking multiple medications) increases risks of clinical concerns including falls arising as side effects to medication use. Limiting pain medication to one medication in each class at the lowest possible dose minimises this risk⁶⁹.

For certain classes of medications, either a review or stop order should be in place. When using NSAIDs for older residents, a review or stop order should be routine after two weeks of treatment. Pharmacists should also regularly monitor NSAID use in RACFs.

For residents taking opioids, a formal regular assessment should be overseen by the resident's GP.

When treating neuropathic pain, response to medication and the severity of side effects can vary greatly. Each resident needs to be closely monitored and regularly assessed. Medication should continue only when the therapeutic benefit (such as pain reduction or functional improvement) outweighs any side effects.

Re-evaluate and monitor medications after a significant change in a resident's health status. This could be due to a fall, admission to a hospital, or an increase in the behavioural or psychological symptoms of dementia. Such changes should prompt a medication review.

⁶⁹ Refer to Chapter 6 of *Pain in RACF 2nd Ed* for more information about polypharmacy.

Case studies: monitoring and evaluation of pain management

Case study: Mario

To monitor Mario's pain, the PCAs and nurses regularly observed his behaviour during the day and night and while he was both resting and moving. They also learned how to communicate questions about pain with Mario with assistance from his children to overcome the language barrier.

To monitor Mario's pain, the Numeric Rating Scale (NRS) (with visual aids to help with the language barrier) was used by a PCA every week until he was no longer experiencing burdensome pain.

Staff referred to Mario's Pain Care Goal Plan to regularly monitor his progress towards achieving his goals and ensure that the specified actions were taking place.

A pain assessment using the M-RVBPI was scheduled to be completed every three months. In the first 6 months after Mario's treatment plan was initiated, it appeared that Mario's pain was being managed well. He was regularly attending sessions with the physiotherapist, participating in exercise activities and doing gardening often. Mario was sleeping much better and socialising well with other residents.

After about 12 months, a PCA noticed that Mario was resting increasingly more than usual and that he was beginning to grimace when moving in and out of his chair and bed. The PCA asked Mario if he was in pain, and Mario indicated that he was. The PCA documented this and advised a nurse. The nurse notified Mario's children and initiated another comprehensive pain assessment.

Referring to the outcomes of the assessment, the nurse, GP and physiotherapist met to revise Mario's treatment plan. The GP discussed with Mario and his family about the benefits and potential harms of NSAIDs, and with their consent, prescribed a NSAID to enable him to participate comfortably in the short-term. This trial was for a time-limited period (one month, with careful monitoring).

Case study: Margaret

The Abbey Pain Scale was used every fortnight to monitor Margaret's pain in relation to the treatment. In the first 3 months after admission, Margaret's pain seemed to improve. Margaret was quite distressed and agitated in the first week after admission, but after a few weeks of pain treatment and getting into a routine including relaxation therapies, massage, exercise and activities, Margaret's behavioural symptoms indicating pain appeared to improve greatly. Her scores on the Abbey scale decreased from moderate to mild.

Margaret's response to her pain medication (an opioid) was monitored continuously. Care staff were especially vigilant for side effects including constipation, loss of appetite and dizziness. When a care worker noticed during personal care that Margaret was experiencing constipation, a nurse conducted a bowel assessment and made changes to her dietary plan and implemented laxative therapy with guidance from the GP. Care workers made sure that Margaret was always drinking enough fluid.

End of life

Margaret continued to receive treatment for her cancer and bone metastasis at the hospital. Although her condition was maintained for about a year, eventually it was apparent that she was reaching end of life and required palliative care. Margaret began rapidly deteriorating: she became incontinent, was less able to eat or drink, and was increasingly weak and confused. Correspondence from the hospital indicated that her cancer was at an advanced stage.

The care team at the facility, along with Margaret and her family, had completed an Advance Care Plan on admission to the facility. To Margaret and her family, it was important that if she had deteriorated to a point where she completely lost

PCAs were advised to be vigilant for any related side effects (e.g. signs of gastrointestinal bleeding, abdominal pain, dark stools, signs of impaired renal function including change in urine output, and fatigue oedema).

The Numeric Rating Scale (NRS) was again used by PCAs every week to assess Mario's pain.

Non-pharmacological options were expanded. The physiotherapist adjusted Mario's massage and exercise treatments. Creative activities that Mario enjoyed were adapted and mindfulness (relaxation) techniques explored. Mario expressed interest in trying acupuncture and started attending acupuncture sessions outside of the facility with a registered specialist in Chinese Medicine. The nurse provided some education to the care staff looking after Mario around how to best help him move during personal care. This was also documented in his case notes.

Mario's pain appeared to lessen to a level that Mario said he could manage. All staff took care to be especially vigilant for any signs of pain on an ongoing basis, and three-monthly assessments using the M-RVBPI were recommenced.

independence, required high-level care and was no longer communicative, that any restorative treatments should be discontinued and that her comfort should be maximised. Margaret had been a practicing Catholic all of her life, and it was her belief that if life support was ultimately futile, then it should be stopped.

Analgesic and other palliative medications were pre-emptively prescribed and administered as Margaret reached her final days. Facility staff provided support and communicated with Margaret's family on a regular and ongoing basis. When Margaret died, her family believed that her wishes according to her Advance Care Plan had been followed. She experienced minimal pain or suffering, and she had ultimately been in control of the final days of her life because her wishes had been recorded and followed.

Glossary of Terms

Abbey Pain Scale: Records the severity and frequency of observed vocalisations, facial expressions, changes in body language or behaviour, and any physiological or physical changes

Acute pain: Pain related to an injury or disease of less than 3 months

Adjuvant Therapy: additional treatment given after the initial treatment

Advance care planning: Making plans about future health care

Allied health: Health professionals who are not doctors, dentists or nurses

Allodynia: Pain that is provoked by usually non-painful stimulation such as light touch

Analgesic: (A drug) that can relieve pain

Antidepressant: (A drug) used to treat depression

Antiepileptic: (A drug) used to treat epileptic seizures

Behavioural: What we do

Behavioural and Psychological Symptoms of Dementia (BPSD): Symptoms associated with the progression of dementia, including agitation, unusual motor behaviour, anxiety, elation, irritability, depression, apathy, disinhibition, delusions, hallucinations, and sleep or appetite changes

Bio-psycho-social: Involving biological, psychological and social factors

Care workers: Non-medical staff of a residential aged care facility who care for the residents

Catastrophising: Thinking deeply and having a magnified feeling of helplessness

Central Sensitisation: When a person becomes more sensitive to pain

Chronic pain: Pain that lasts for more than 3 months, even when the initial injury or illness has resolved. Chronic pain is also known as persistent pain

Collaborative: Working together

Comorbidities: One or more additional diseases that exist at the same time as a primary disease

Cognitive behavioural therapy (CBT): Type of psychotherapy which works on unhelpful thinking and/or behaviour

Cognitive: Related to thinking and understanding

Contracture: A condition of shortening and hardening of muscles, tendons, joints or other tissue

Diabetic neuropathy: Nerve damage that is a complication of diabetes

Delirium: an acute change in mental status that is common among older people when unwell. Characterised by a disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours to a few days)

Dementia: Memory problems, personality changes, and impaired reasoning caused by a brain disease

Dietician: An expert on diet and nutrition

Dysarthria: A type of speech problem

Dysphasia: A problem with language and sometimes understanding, caused by brain disease or damage

Enrolled nurse: A nurse qualified to provide care under the supervision of a Registered Nurse, and is and enrolled with the Australian Health Practitioner Regulation Authority.

End of life care: Includes physical, spiritual and psychosocial assessment, and care and treatment delivered by health professionals and ancillary staff. It also includes support of families and carers, and care of the patient's body after their death

Fear avoidance: Excessive and debilitating fear of moving and activity

Flares: A sudden increase in pain

Frailty: a clinically recognisable state in which the ability of older people to cope with every day or acute stressors is compromised by an increased vulnerability brought by age-associated declines in physiological reserve and function across multiple organ systems

Gait: How someone walks

General Practitioner (GP): A family doctor based in the community

Holistic: Concerning the whole system

Hyperalgesia: Abnormally heightened sensitivity to pain

ICF: International Classification of Functioning, Disability and Health: a bio-psycho-social framework to disability developed by the WHO

Indicated: There is a reason to use a certain drug or treatment

Interdisciplinary: Related to more than one branch of knowledge (multidisciplinary is a related but distinctly different term)

Linguistic: About language

Manoeuvre: A movement or series of movements

Manual therapy: A type of therapy using hands-on techniques

Mind-body: Taking into account the thoughts, emotions, or spiritual practices that can affect how the body functions

Mindfulness-Based Stress Reduction: A program that helps calm the mind and body to cope with illness, pain or stress

MNA: Mini Nutritional Assessment

M-RVBPI: Modified Resident's Verbal Brief Pain Inventory

Multidisciplinary team (MDT): Group of health care workers who are members of different disciplines (Interdisciplinary is a related but distinctly different term)

Neuropathic: Disease of the nervous system

Nociceptive: Pain due to the stimulation of nerve cells

Nociplastic: Nervous system sensitisation without evidence of nerve damage

Non-pharmacological: Without the use of medications

Non-sedentary: Not involving being seated or inactive

NSAIDs: Non-steroidal Anti-inflammatory Drugs, used to treat pain and inflammation Common NSAIDs include ibuprofen and naproxen

NRS: Numeric Rating Scale

Occupational therapist: Allied health worker who uses certain activities as an aid to recuperation from physical or mental illness

PCA/PCW: Personal Care Attendant/Assistant or Personal Care Worker

PAINAD: Pain Assessment in Advanced Dementia Scale

Pain in RACF 2nd Ed: Abbreviated title for the book, Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition

Pain-vigilant culture: Pain vigilance is when everyone in an RACF is constantly mindful of pain and works as a team to identify pain in a timely way.

Pain-therapeutic culture: Evidence-based pain care processes are available, accessible and put in place

Palliative care: Form of health care that helps people live as fully and comfortably as possible when they have a progressive illness that will lead to death

Persistent pain: See chronic pain

Person-centred care: People who receive health care are seen as equal partners in planning, developing and monitoring care to make sure it meets their needs

Personal care attendant/assistant (PCA): Staff who provide personal care to residents

Pharmacological: Concerning the uses, effects and modes of action of drugs

Placebo: A medication that has no therapeutic effect

Post-herpetic neuralgia: A complication of shingles that affects the nerve fibres and skin, causing burning pain

Polypharmacy: Taking multiple medications

PWD/PLWD: Person with Dementia/Person Living with Dementia

Quality assurance: Maintaining a certain level of quality

RACF: Residential Aged Care Facility

Recurrent pain: When acute pain comes and goes or flares up (for example, pain from rheumatoid arthritis as the disease process fluctuates)

Regimen: A prescribed course of medical treatment

Registered nurse: A nurse with a Bachelor of Nursing degree or equivalent who is registered as a nurse with the Australian Health Practitioner Regulation Authority

Sensitisation: When repeated stimulation makes the response progressively greater

Stoicism: Enduring pain or hardship without complaining

SGA: Subjective Global Assessment

Synchronised: Happening at the same time

Tolerance: Being able to tolerate a drug without a reaction

VAD: Voluntary Assisted Dying

VDS: Verbal Descriptor Scale



This is the end of the PMG Toolkit 2nd Edition

Click one of the links below to navigate to earlier sections.

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[Section B: About Pain](#)

[Section C: Systems and Governance](#)

[Section D: Pain Management \(4 Steps\)](#)

[Four Steps to Pain Management Flowchart](#)

[Printable Resources](#)