IAHHC

A Letter From Home

February 2016

Pain

More than two thirds of all Americans suffer from multiple, chronic conditions. An estimated 60-70% of people over 65 report at least some persistent pain (Centers for Disease Control and Prevention, 2013). According to National Institute of Health, pain affects more Americans than diabetes, heart disease and cancer. So, pain is an inevitable part of working with clients in the home care industry. As a result, it is important that you understand the different types of pain, how to observe for pain and what you can do to assist your clients.

The International Association for the Study of Pain (2012) defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage". However, a more familiar definition of pain is, "pain is whatever the person experiencing pain says it is, occurring where they say it does (McCaffery and Beebe 1999). Because there are no tests to determine if a person is experiencing pain, the most accurate evidence of pain and its intensity is based on the clients self-report. And, to complicate matters, pain can have different meaning to different people; and its perception can be affected by their previous experiences, psychological state, culture, gender, and physical condition.

One cannot really compare pain experiences with one another or from one client to another. People often have different ways of coping with pain and may not look to an outsider to have pain. And, people experience different behaviors when they are in pain. Some may sleep a lot, or very little. Some may use a distraction, such as television to cope. It is important to always believe the patient and remember that pain is whatever they say it is.

Pain often involves the whole person as well as those around them. Almost 80% of chronic pain clients report that pain disrupts their activities of daily living and two thirds indicate that pain has negatively impacted personal relationships.

It is important to recognize and assist the client with treatment of pain as pain is multi-dimensional and affects many aspects of their lives and their family. Pain can interfere with a client's sleep, appetite and level of functioning. Older adults with severe, persistent pain are twice as likely to report difficulties in initiating sleep, in staying asleep, and with sleeping longer than usual (Chen, Hayman, Shmerling, Bean, & Leveille, 2011). Consequently, as many as 42% of middle-aged and older adults with persistent pain experience chronic sleep deprivation (Artner et al., 2013) It also has psychosocial effects and can cause a change in social and close relationships, isolation, loss of self-esteem and increased caregiver burden. Problems with mood, including risk for clinically significant depression are also important consequences of persistent pain in older people (Molton and Terrill, 2014) Pain can also create undue financial burdens from inability to work, potential loss of insurance, cost of pain medications and increased health care costs. Finally, pain can create emotional and spiritual burdens to the client. These may include increased fear and anxiety, depression, and questioning the meaning of suffering.

Many older adults perceive pain as "normal" or "expected" due to aging. It is important to remember that pain severe enough to interfere with functioning or the ability to do things they enjoy, is not a normal part of aging. Fear of not being believed or of being labeled a hypochondriac, wanting to be a "good" patient, and not wanting to be a burden have also been suggested as contributing to the underreporting

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or minimizing of pain symptoms in older people (Molton and Terrill, 2014)

In learning about pain, it is important to understand there are different types of pain. Acute pain generally starts suddenly and can cause a client's blood pressure and pulse to increase. It can cause sweating and tense muscles. Generally, acute pain is self-limiting and decreases as the problem is fixed and generally has a good response to analgesics. Acute pain can actually be a good thing as it allows us to know that there is something not right with our body, such as sore muscles, broken bones or a cut or burn.

Chronic pain in contrast, usually lasts for 3 months or longer and may not have an affect blood pressure or pulse. In chronic pain, the pain is no longer beneficial and has overstayed its welcome. Chronic pain has been associated with significant changes in personality, lifestyle, and functional ability. Examples of chronic pain include arthritis or low back pain.

Neuropathic pain results from an actual injury or dysfunction in nerves and arises from an abnormal processing of sensory input. It is often described as burning, shooting, tingling, numbness or electrical shock. Examples are shingles, pain after a stroke or phantom limb pain. Neuropathic pain can be difficult to treat and many conventional pain medications are not effective.

Somatic pain results from injury to parts of the body such as bones, joints, and soft tissues. It is usually well localized, and is often described as sharp, dull, aching, throbbing or gnawing. With somatic pain, the person can usually point to exactly where it hurts. This type of pain can usually be controlled with pain medications.

Visceral pain often results from inflammation, distention, or stretching of the internal organs. Often this pain is referred to distant sites, making it hard to pinpoint. It is described as cramping, aching, squeezing or pressure. Examples are bowel obstruction, appendicitis or gall bladder issues.

In addition to physical aspects of care, many often experience psychological or spiritual pain that may result from sadness or loss. This complicates the experience of pain and cannot be managed with medications.

One of the best ways you can help a client experiencing pain is to know what to observe for and what to ask a client so that you can report this to your supervisor, family, or health care provider. Some questions to ask:

- Where is the pain, ask for all sites
- How much does it hurt?
- When do you have pain?
- Describe your pain. They may use descriptive words such as dull, aching, stabbing, sharp
- What makes your pain better or worse?
- Does anything else affect your pain
- Is there something you can no longer do because of the pain?

Some clients are non-verbal or may be unable to report pain. Those who are cognitively impaired may be especially at high risk for under-treatment for pain. For those that are unable to verbalize pain, it is important to collaborate with the family and other caregivers and observe for physical signs of pain. Pain in those with dementia may contribute to problems such as aggression, agitation, withdrawal, and increased confusion. Pain in a person with dementia is often not interpreted in a normal way. Therefore, they may show

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little signs of pain, even when ambulating with a fracture, or may exhibit excessive reactions to a pain that may not usually cause significant pain. Carefully observe behavior and reactions of older adults with cognitive impairment for pain. Consider pain first with any change in behavior. Other signs of pain may be:

- Moans
- Grunts
- Signs
- Not wanting to move
- Restlessness and pacing
- Grimacing
- Frowning, or wincing
- Increased pulse or breathing
- Resisting care
- Change in sleep or appetite
- Striking out

You will want to check your client for pain whenever they report pain, before, during and after care activities, when instructed and after pain medication s given.

Treatment

The benefits of well-controlled pain and the risks of analgesic use are complicated and often challenging for health care professionals and clients alike. There are many types of medications that are used to treat pain. The World Health Organization has a pain ladder that is the standard for medication treatment for pain.

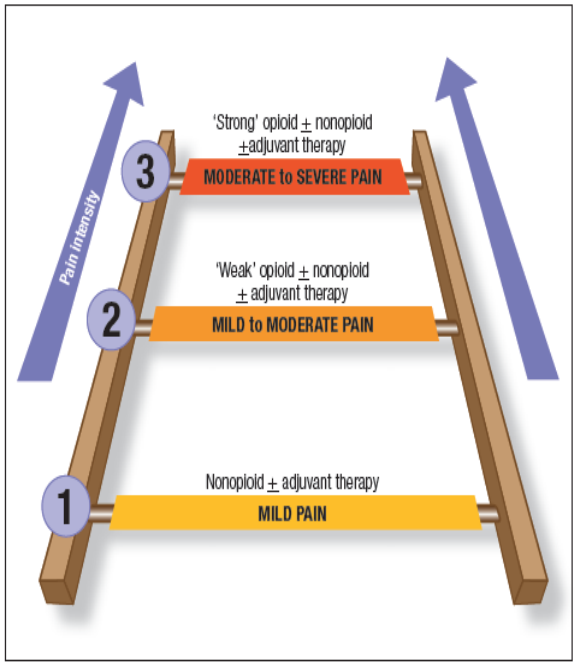

Figure 1. WHO Three-step Pain Ladder. This analgesic step ladder has been the treatment standard most used during the past 3 decades.

Step 1 pain medications such as acetaminophen (Tylenol) or anti-inflammatory drugs such as ibuprofen or aspirin are sometimes not indicated for certain populations due to the increased risk of adverse effects, especially gastrointestinal bleeding and kidney and liver impairments. Acetaminophen overdose sends as many as 78,000 Americans to the emergency room annually and results in 33,000 hospitalizations a year, federal data shows. It is estimated that over 16,000 NSAID (non-steroidal anti-inflammatory drugs) related deaths occur each year among patients with arthritis, making it the fifteenth most common cause of death in the US. But, when used as directed, these medications can be very effective for treating mild pain. They may be used alone or as an addition to other pain medications to help treat pain. If the client is taking acetaminophen or ibuprofen, they must make sure that other over the counter

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medications, such as cold medications that may contain these ingredients, are not given as there is a ceiling dose on these medications. This means there is an upper limit to the amount of these medications that should be taken. Older clients and other special groups often have a lower daily suggested dose.

Adjuvant drugs have been developed for purposes other than to relieve pain, but are thought to alter or modulate the perception of pain. Many of these medications are anti-depressants or anti-seizure mediations. They may be used alone or in combination with non-opioid or opioid analgesics. They are usually most effective for neuropathic types of pain

Opioid medications are used for acute pain as well as chronic pain. Opioids can be long acting for more continuous pain, or short-acting for acute pain needs. Opioids can have several side effects, some of which will resolve in a few days, others that persist while the client is taking the mediation.

Sedation and impaired cognition may occur when opioid analgesics are initiated or the dose is increased. Opioids can be safely used with clients but careful observation for side effects and toxicity should occur. Older clients are often hesitant to use opioid medications, because they fear they will become addicted. And while addiction can occur, it is rare in older adults who are using their mediation for pain management.

Some of the most common opioid side effects include:

Constipation: The primary side effect to opioid treatment is constipation. Tolerance to this side effect does NOT occur. So if a client is taking a narcotic pain medication, they will develop constipation because opioids delay gastric emptying, slow bowel motility and decrease peristalsis. Diet and exercise will beimportant if tolerated. It will also be critical to increase fluids as possible.

Itching: Itching may occur with the use of certain opioids, especially those with morphine. The itching may be generalized but is usually localized to face, neck and chest. It is usually not accompanied by a rash. The client may need to use an oatmeal bath or notify the MD for additional symptom relief. Itching usually resolves in a few days, but if not, the MD may need to be contacted to change medications.

Nausea/Vomiting: This may occur for a number of reasons including slowing of the GI tract, the effects on a client's balance and equilibrium of inner ear or stimulation to the chemoreceptor trigger zone in the brain. Nausea/vomiting also generally resolves after a few days, but the MD may need to be contacted so that medications can be used to combat the nausea.

Balance/falls: Older adults, particularly, should be regularly monitored for their fall risk while taking pain medications.

Respiratory depression: When many people think about the use of opioid pain medication, they are often concerned about respiratory depression. However, it is very rare to have this side effect in a client who has been receiving pain medication for more than a few weeks. If a client or family is concerned about respiratory depression, they can monitor the client's sedation and respiratory rate every 1-2 hours for the first 24 hours or after a dose increase.

When a client has persistent pain, it is often best for them to take their pain medications around the clock, meaning at regularly

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scheduled times. Many clients think they should only take pain medications once they are in excruciating pain. However, studies have shown that a client that takes doses on an "as needed schedule" take higher doses to relieve pain and starts a cycle of under-medication alternating with times of over-medication.

There are also many well-recognized and accepted non-medication means to assist with pain with clients. These may include:

- Distraction/imagery. You can work with the client or family to determine what is a favorite thing that may distract the person in pain. It can be looking at family pictures, a favorite tv show, thinking of a favorite family vacation, etc
- Relaxation. You can assist the client by having them participate in some deep breathing.
- Music
- Aromatherapy
- Positioning
- Heat/cold. If approved with MD

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