Pain
Prevention and Wellness Practice Guideline

Overview of the Condition/Disease

Definition: Pain is a signal in your nervous system that something may be wrong. It is an unpleasant sensation that can range from mild, localized discomfort to agony. Pain may come and go or be constant.

Pathophysiology: There are several types of pain an individual may experience. They can occur themselves individually or in combination at the same time causing a mixed pain pattern.

- Nociceptive Pain- typically the result of a tissue injury such as osteoarthritis pain, back pain, or post-surgical pain
- Inflammatory Pain- an abnormal inflammation caused by an inappropriate response by the body's immune system such as in gout or rheumatoid arthritis
- Neuropathic Pain- caused by irritation of specific nerve (s) such as neuropathy
- Functional Pain- pain without a specific origin such as with fibromyalgia and irritable bowel syndrome
- Chronic Pain- pain that has persisted for 3 to 6 months or longer; often due to a combination of biological, psychological, and social factors; usually requires a multifactorial approach to evaluation and management; is often associated with depression and/or anxiety.

Best Practice Standards for Prevention and Management

Education: Pain is not a one size fits all. People experience pain in all different areas of the body and have varying tolerances to pain. Appreciating a person's pain symptoms and their understanding of the significance of the pain and communicating these to a healthcare provider is very important. Factors to consider when assessing pain include:

- Location of the pain
- Intensity of the pain
- Quality of the pain
- Onset of the pain (when it first started)
- Activities the person is unable to complete due to the pain
- How often the pain occurs
- How long the pain lasts
- What makes the pain better
- What makes the pain worse
- What the member believes to be the cause and/or meaning of the pain

Interventions: The best intervention for prevention and management of pain is to ensure effective assessment of a person's pain to determine an appropriate treatment plan. To do this, the assessing individual must consider the person's cognitive ability to express pain and choose the most appropriate pain assessment tool from one of the following:

- Normal Cognition to Mild Cognitive Impairment and persons with intellectual and developmental disabilities
    - Numeric Pain Scale: Staff will ask the member to rate their pain on a scale of 0-10 with 1 being little to no pain and increasing with 10 being the highest pain.
    - Wong Baker (FACES) Scale: Staff will show member the scale and have the member choose a facial expression to best describe their pain.
- Mild Cognitive Impairment to Moderate Cognitive Impairment
    - PAINAD Scale: Staff will observe the member's behaviors for five minutes before assessing them and scoring them on a scale of 0-2 based on the chart. At the end of the assessment the numbers are summed from each category for a total score. A score of 1-3 equals mild pain, 4-6 equals moderate pain and 7-10 equals severe pain.
    - Abbey Pain Scale: Staff will observe the member while assessing them in six categories. Score the member based on 0=no behavior to 3=severe behavior. Total the scores in each category to determine the member's pain level. 0-2 = minimal or no pain, 3-7 = mild pain, 8-13 = moderate pain and 14 or above = severe pain.
- Moderate Cognitive Impairment to Severe Cognitive Impairment
    - PACSLAC Scale: This pain assessment scale works best with members who are non-verbal with cognitive impairment. The scale is completed upon the initial visit to establish a baseline score. If the member presents with the behavior, place a check mark next to the behavior. Each assessment following, is scored against the baseline category. If the member is exhibiting a new behavior or in the absence of baseline behaviors, the member should be referred to their primary care physician or pain management specialist for additional assessment and interventions.

Anticipating, Recognizing, and Responding to Symptoms

Seek timely medical attention when current interventions and/or medications are not managing symptoms.

Potential symptoms: sharp, stabbing, throbbing, burning, tingling, weakness, numbness, dull/achy

Manifestation of symptoms: nausea/vomiting, restlessness, agitation, irritability, grimacing, anxiety, depression, change in eating habits, disturbed sleep, dizziness, blurred vision, crying/groaning

Interventions to manage symptoms:

- Non-pharmacological Interventions: used alone or in combination
  - Heat or cold therapy: Do not apply ice directly on the skin. Do not use ice or heat continuously for longer than 15 minutes.
  - Vibratory/massage therapy
  - Physical therapy (PT): therapeutic exercise, stretching
  - TENS (Transcutaneous Electrical Nerve Stimulation) therapy
  - Acupuncture
  - Chiropractic therapies: spinal manipulation
  - Cognitive-behavioral therapy
  - Relaxation Techniques
    - Meditation
    - Distraction e.g., activities such as listening to music, watching TV
    - Deep breathing exercises
  - Yoga/stretching/relaxation exercises
  - Guided imagery
  - Aromatherapies/essential oils
- Pharmacological Interventions – The type of medication used is based on the type of pain the individual is experiencing. All medications should be prescribed and monitored by a licensed healthcare professional.
  - OTC (Over the Counter) Pain Relievers- Antipyretic (Tylenol/acetaminophen))
  - OTC Nonsteroidal anti-inflammatory drugs (NSAIDs)- Aspirin, Aleve (naproxen), Advil (ibuprofen), and Motrin (ibuprofen)
  - Topical analgesics- Lidocaine, Diclofenac topical, Capsaicin cream
  - Antidepressants- Tricyclic and tetracyclic antidepressants (amitriptyline, imipramine) and serotonin-norepinephrine reuptake inhibitors (venlafaxine and duloxetine)
  - Antiepileptics- Gabapentin, Pregabalin, and Carbamazepine
  - Muscle relaxants- Methocarbamol, Metaxalone, Carisoprodol, Cyclobenzaprine, Tizanidine
  - Opioids- Tramadol, Vicodin (hydrocodone-acetaminophen), Percocet (oxycodone-acetaminophen), Oxycodone (These medications are highly addictive and must be prescribed and monitored by a licensed physician). Be aware of opioid-acetaminophen combinations and that the maximum recommended acetaminophen dose per 24 hours has not been exceeded.
- Surgical and Dental Interventions- considered when other modalities would be or are ineffective and are focused on addressing the likely cause for the pain, examples include:
  - Trigger point injections: e.g., nerve blocks

- Joint Aspiration
- Spinal discectomy
- Root canal (dental procedure)

Guidelines and Process for Interdisciplinary Team

The care team nurse will assess member's pain at the initial, annual, and six-month assessment and as needed when contacting the member. They will ensure member has a plan for managing their pain and assist them with coordination of medical appointments for their primary care physician or pain management specialist.

Cultural Considerations

- In general: ethnic and cultural minority groups have continued to experience a disproportionate burden of disease, injury, premature death, and disability when compared to the white population.
- Health disparities can mean lower life expectancy, decreased quality of life, loss of economic opportunities, as well as perceptions of injustice.
- Health disparities are reflected in decreased productivity, increased health care costs, and social inequities.
- Contributing factors to ethnic, cultural, and gender disparities:
  - Mistrust in the health care system (stemming from historical mistreatment or neglect)
  - Personal and group experiences of discrimination
  - Lack of health literacy
  - Provider prejudice or unconscious bias
  - Lack of cultural competency and clinical humility among health care providers
  - Discordance in patient-provider gender, race and/or ethnic background
  - Lack of minority representation among health care providers (only 19% of RNs in the workforce are from a minority background)
- Racial/ethnic minorities have generally received less adequate treatment for acute and chronic pain management regardless of age, gender, and pain intensity.
- Pain intensity underreporting by minority individuals appears to be a major contributing factor to disparities in effective pain management.
- Another major contributing factor include a healthcare provider's unconscious bias, lack of personal awareness of own cultural beliefs, and stereotypes regarding pain reporting and use of narcotic analgesics in minority populations due to years of systemic racism integrated into the education and health care systems.

All ethnicities and genders are at risk for inadequate pain management, but research shows some are at higher risk. Please be considerate of members at higher risk and make sure to provide education when necessary.

Quality Assurance Monitoring

Internal file reviews are completed by internal staff to monitor members reporting pain. The internal file review monitors the member has appropriate pain management interventions documented in their care plan including coordination and follow-up of member visits to their primary care physician or pain specialist.

Additional Resources

Numeric Pain Scale

Wong Baker (FACES) Scale

PAINAD (Pain Assessment in Advance Dementia) Scale

Abbey Pain Scale

PACSLAC (Pain Assessment Checklist for Seniors with Limited Ability to Communicate)

References

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