Pain in Palliative Care

Heather Tonner
Advanced Nurse Specialist in Palliative Care
Care Home Collaborative

Aim

To increase understanding of palliative care pain

Learning Outcomes

Greater awareness of different types of pain experienced by individuals with palliative needs

Recognise the importance of pain assessment and consequently its impact on good pain management

Definitions of Pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage”

(International Association for the Study of Pain 1972)

“Pain is what the experiencing person says it is, and exists whenever the experiencing person says it does”

(McCaffery and Pasero 1999)

Causes

- Disease
- Treatments
- Concurrent Illness
- Injury
- Emotional distress
- Spiritual distress

Types of Pain

- Acute - Short term, intermittent pain
- Chronic - Constant and persistent pain
- Neuropathic - Peripheral and/or CNS injury
- Nociceptive - Somatic – (bone, soft tissue e.g. skin, muscle)
  Visceral – (stretching of viscera e.g. liver)
  Breakthrough/Intermittent
- Total Pain

Why Assess Pain?

- Accurate assessment and diagnosis of the type of pain is essential for planning appropriate intervention and successful management of pain

- Successful assessment and control of pain ultimately depends on a trusting, positive relationship between resident and nurse/carer

Pain Assessment

- Pain is always **subjective -** the clinician needs to accept and respect this self-report
- Older adult's self-report of pain is the single most reliable indicator of Pain
- Pain can exist even when no physical cause can be found, should not be attributed as psychological or discounted
- Physiological and behavioural (objective) signs of pain (e.g. tachycardia, grimacing) are neither sensitive nor specific to pain
- Include family members in the assessment process, when possible
- Assessment approaches, including tools, must be appropriate for the older adult

Pain Assessment

Challenges

- Individuals who are unable to communicate - special consideration is needed
- A uniform pain threshold does not exist i.e. different pain experience to the same stimulus
- Pain tolerance varies among and within individuals depending on factors including heredity, energy level, coping skills, and prior experiences with pain

Pain Assessment

- Individuals who suffer with chronic pain may be more sensitive to pain and other stimuli (remember with older adults)

- Unrelieved pain has adverse physical and psychological consequences therefore staff must encourage reporting particularly from the:
  - Reluctant disclosers
  - Pain deniers
  - Poor treatment compliers

Pain Assessment

As pain is an unpleasant sensory and emotional experience, assessment must include physical, psychological, spiritual and emotional aspects of pain

Other important considerations:

- Evaluate the response to previous and current therapies
- Evaluate the psychological state of the patient
- Check for past history of drink/drug dependence
- Reassess the response to treatment

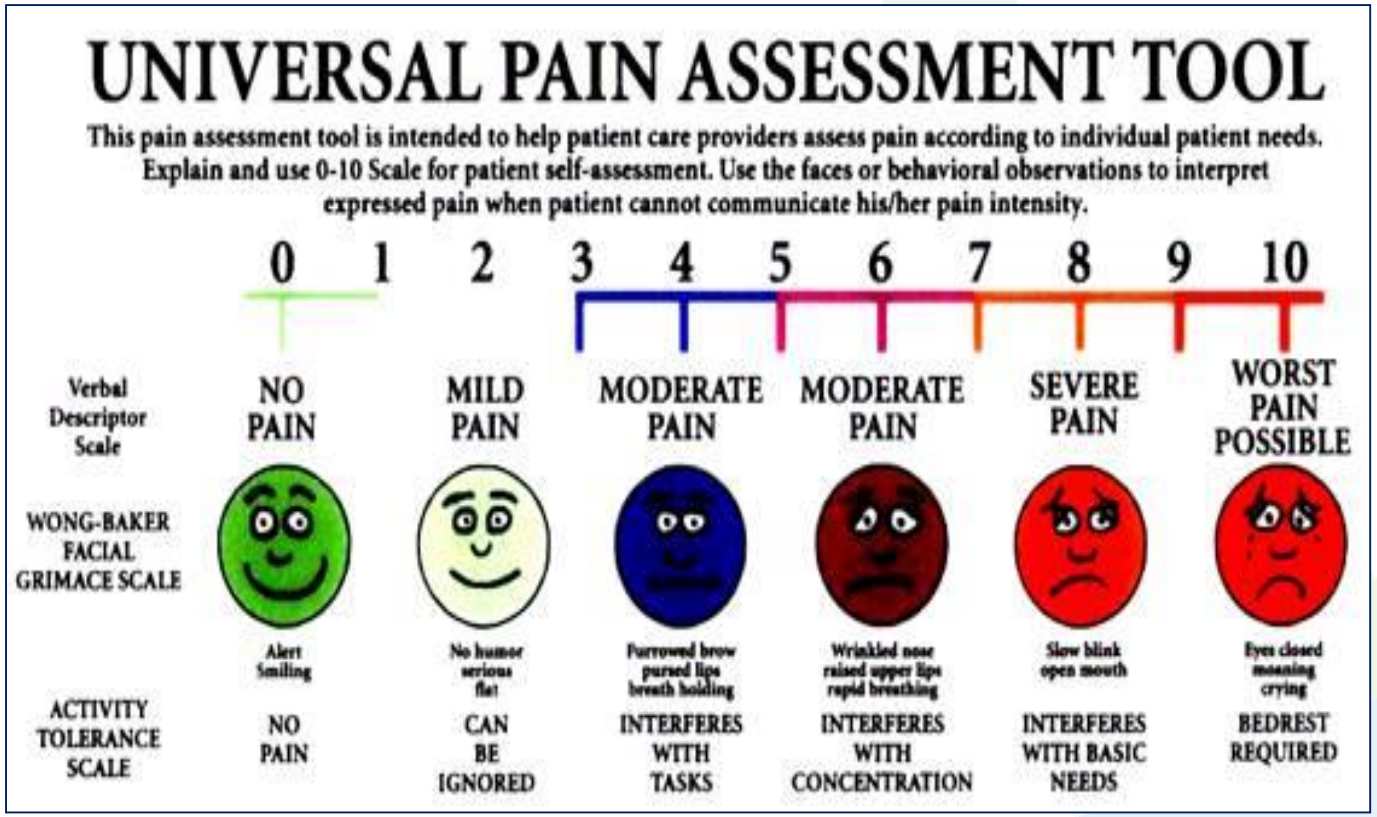
Pain Assessment when there is Cognitive Impairment

- Take into account individual's history, interview information and results of physical examination
- Use assessment processes that include both self report and observational measures when possible
- Use of Pain Assessment Tools

Pain Assessment Tools

Mild to Moderate Cognitive Impairment

- The Numeric Rating Scale (NRS), Verbal Descriptor Scale (VDS), Faces Pain Scale Revised (FPS-R)



Pain Assessment Tools

Advanced Cognitive Impairment

- Pain Assessment in Advanced Dementia (PAINAD) is recommended for monitoring directly observable behaviours on a regular basis in older adults with chronic pain

Pain Assessment Tools

PAINAD

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
				TOTAL

Warden, Hurley, Volicer, JAMDA 2003; 4(1): 9-15

Pain Assessment when there is Cognitive Impairment

- Pain assessment during a movement (transferring, bathing, dressing) is more likely to identify an underlying persistent pain problem than observation at rest
- An analgesic trial will help to determine if behaviour changes are related to pain.
- Wider MDT input may be required. Consider Specialist Palliative Care Team input if the pain is complex and the existing team are unable to manage it.
- If pain impacts on other ADL's, assessment should include relevant evaluations

Care Home Collaborative

www.nhsggc.scot/your-health/care-homes/care-home-collaborative/

Questions?