


Clinical Pain Management



An Essential
Handbook
for Long-Term
Care Nurses

Barbara Acello, MS, RN

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HCP Pro

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Disclaimer

The information listed here is for educational purposes only. Always follow your facility policies and procedures and physician orders. Confirm all medication dosages carefully before use. The author and publisher make no claims as to the accuracy of the information. Every effort has been made to ensure that this material is timely and accurate at the time of publication, but pain management involves evidence-based practices that change frequently and rapidly. The doses suggested here are not a substitute for clinical judgment. Neither the author or publisher or any other individual or party involved in the preparation of this information shall be liable for any special, consequential, or exemplary damages resulting in whole or part from any individual's use of or reliance upon this material.

From the Author

An old maxim is that long-term care facilities are more highly regulated than nuclear power. One area of recent regulatory scrutiny is pain management. In fact, hospitals, The Joint Commission, and others were focusing on the need for improved management long before the long-term care regulatory agencies revised the pain standards. Pain management isn't really about rules. Being free from pain should be a basic human right, and by doing all you can to identify and alleviate pain, you are improving the quality of care in your facility and the quality of life for your residents. With this in mind, the goal of this book is to help make your job easier by providing essential information to achieve these goals without complex layers of useless information.

The need for pain management is not new, and the revisions in the federal quality of care rules recently expanded and clarified existing information. The goal is to help facilities focus on pain, meet the needs of the residents, and achieve survey compliance in the process. You will find some of the information new and interesting. Drugs and other treatments that were introduced through 2009 are included. The book also contains useful clinical pearls, helpful factoids, and functional tools with which to do your job.

This book is a reference guide of information and resources that will help you survive and thrive in providing pain management in the long-term care facility environment. It is not to provide a primer to insult your intelligence. You already know how to be a nurse, so it is not a rehash of familiar policies and procedures. It was not written to be highly technical, theoretical, or to present the results of complex research. Rather, the primary goal is to provide information and tools that will be practical and functional to nurses in developing,

enhancing, improving, or revamping a pain management program. The book focuses on resources you need, information that will be helpful, and beneficial information for administering a successful program. It is not meant to be an exhaustive or comprehensive source of information, such as a text book. The book includes current clinical information that will complement more exhaustive sources of long-term care nursing reference material. Some of the information is likely to be new, and some not. Take what makes sense and adapt whatever works to your facility and your residents. Pain management is so highly individualized that providing rigid rules is impossible.

You have an enormous mission and responsibility. The essence of quality is the manner in which staff members consider and relate to residents as individuals. Quality of life is the result of a culture of caring. When the facility has a culture of caring, quality of care flourishes. This culture is created on the shoulders of strong nursing leaders with a vision. The residents derive many benefits, and you will derive more job satisfaction than you ever thought possible. Believe in yourself and in the many positive aspects of providing pain management. Don't view it as a chore. Long-term care nursing is a calling, and we hope this book provides you with useful tools with which to begin the pain management process. Over time, many people will benefit and recognize how sacred the work we do is.

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Good luck with your mission to provide quality pain management. Geriatric care is my first love, and I sincerely admire those who work in the difficult financial and regulatory environment we call long-term care. I believe in you, admire your commitment, and sincerely hope this information is useful to you. Please feel free to contact me through HCPro, Inc., or by e-mail if you have questions or comments.

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Introduction to Pain Management in the Long-Term Care Facility

Introduction to Pain

Pain is a noxious stimulus that is physically and emotionally unpleasant. It is a highly complex phenomenon that often results from injury or sensory stimulation. A variety of factors affect recognition, assessment, and management of pain. Likewise, many factors affect the presence, intensity, and ability to describe pain. Pain is very personal and subjective. The inability to communicate does not mean pain is minor or does not exist.

Pain is also a major preventable public health issue that increases cost and slows recovery. Pain is always a symptom of something wrong. Unrelieved pain has many significant physical and psychological consequences. It interferes with the resident's optimal level of function and self-care. It contributes to immobility, increasing the risk of pneumonia, skin breakdown, contractures, behavior problems, depression, and many other complications.

Pain that affects function or quality of life is a significant problem in long-term care facilities, where up to 80% of the residents have one or more painful conditions.¹ In this setting, musculoskeletal conditions and arthritis are the most common causes of pain.² Problems associated with conditions of the nervous system, such as shingles and diabetic neuropathy, are also

fairly common. Although pain is often associated with tissue damage, no gauge exists to identify a relationship between tissue damage and prevalence of pain. Tissue damage may be present and not visible, or the resident may have pain that seems out of proportion to the visible area of damage.

There are several categories of pain, but sometimes one problem cannot be differentiated from another, and signs and symptoms often overlap. Residents may have more than one painful condition. Because of the prevalence of pain in the geriatric population, maintain a high level of suspicion related to the potential for or presence of pain. This is especially important for cognitively impaired residents with behavior problems, residents who fail to eat, and those who are able but fail to participate in other activities of daily living (ADL), such as dressing, bathing, and ambulating.

Definitions Associated with Pain in Long-Term Care Residents

- **Acute pain** is pain with an abrupt onset and limited duration that is usually resolved in fewer than six months.
- **Cancer pain** is sometimes listed in other categories. Some experts consider it a subtype of acute pain. If the patient lives long enough, the pain becomes persistent. This is pain associated with a known malignancy. It is difficult to classify and may fall into more than one category, such as neuropathic pain and nociceptive pain.
- **Breakthrough pain** is usually associated with pain that is well controlled; it is a transient, situational, or episodic increase in pain that requires treatment with a rapid-acting medication. This type of pain

may also be seen when a drug is wearing off before the next dose is due. If the pain is neuropathic in origin, it may be difficult to predict.

- **Incident pain** is sometimes considered a subtype of breakthrough pain. This is situational or episodic pain that often occurs predictably and is associated with a precipitating event, such as pain on movement or pain associated with a procedure such as wound care.
- **Mixed or unspecified pain** are terms used by some experts to describe pain caused by multiple problems or pain in which the exact cause is unknown, such as severe, recurrent headaches.
- **Nociceptive pain** occurs when receptive nerve endings are damaged or stimulated by touch, pressure, heat, an irritant, etc.
 - **Somatic pain** is a type of nociceptive pain with origins in the muscles, joints, connective tissue, bones, and skin; this pain is usually localized in one area. The resident may complain of throbbing and/or aching. Pain is usually aggravated by activity and relieved by rest.
 - **Visceral pain** is a type of nociceptive pain with origins in the internal organs, such as the gallbladder or gastrointestinal tract; it may be well localized or poorly localized, depending on cause.
- **Neuropathic pain** is associated with abnormal processing of sensations by the nervous system; this category may be further subdivided into peripherally generated pain and centrally generated pain.
 - **Phantom pain** is a form of neuropathic pain that may result in burning, tingling, itching, numbness, or pain that seems to originate in a part of the body that has been removed.

- **Persistent pain** (formerly called chronic pain) was renamed because of prevalent stereotyping and negative attitudes associating this type of pain with addiction and drug-seeking behavior. Persistent pain is a legitimate pain that typically persists beyond a three- to six-month period of time, perhaps for life, and pain is recurrent and of varying intensity. It might not be associated with a known diagnosis. New research suggests that undamaged nerve fibers cause persistent pain. Until recently, researchers believed that damaged nerve fibers were responsible for transmitting pain impulses to the brain.³ This information is useful in the quest to identify more effective analgesics.
 - **Persistent nonmalignant pain** (formerly called chronic, nonmalignant pain) is another term for persistent pain. This type of pain is usually associated with a chronic condition or injury rather than a malignancy.
- **Referred pain** travels to another area of the body through shared nerve pathways, such as chest pain radiating to the jaw and arm, and gallbladder pain radiating to the shoulder.

Other definitions that may be important are:

- **Pain threshold**—the least stimulus-producing pain
- **Pain tolerance**—the greatest level of pain a resident can tolerate
- **Sensory threshold**—the least stimulus a resident can recognize and identify

Characteristics of pain

You may be surprised to learn that each type of pain seems to have a unique description. Having the resident describe the pain is often important during the assessment phase. A summary of the various pain descriptions is listed in Figure 1.1.

FIGURE 1.1		PAIN DESCRIPTIONS	
Type of pain	Description		
Anginal pain	Squeezing, throbbing		
Neuropathic pain	Sharp, severe, stabbing, burning, like electricity or lightning, shooting, burning, hypersensitivity to cold, tingling, pins and needles, stinging, cutting, drilling, numbness, weakness; spinal nerve root pain may be associated with intense itching, may cause skin sensitivity		
Visceral nociceptive pain due to stretching of organ covering	Sharp, stabbing, or throbbing		
Visceral nociceptive pain due to obstruction	A deep aching, may be colicky, cramping, or gnawing; pain may be referred to other areas		
Somatic nociceptive pain	Aching, squeezing, throbbing, sharp, or stabbing; sometimes may be replicated by moving or touching the affected area		
Phantom pain	Squeezing, burning, or crushing		

Pain in Elderly Persons

This section provides a brief overview of pain in elderly persons. Most long-term care nurses see pain in their residents daily. They may or may not recognize it. Nurses are more interested in knowing what to do about the pain than they are in the anatomical and physiological factors associated with it. For more comprehensive information about pain etiology, pain management, and an abundance of related pain information, refer to a more comprehensive text, such as *Pain: Clinical Manual* (McCaffery, M. and Passero, C. 1999. St. Louis, Mosby).

Conditions commonly associated with the development of pain in elderly people

- Abnormal functioning of the peripheral or central nervous system
- Amputations
- Arthritis
- Cardiovascular disorders
- Contractures, complications of immobility
- Crystal-induced arthropathies (e.g., gout, pseudogout)
- Degenerative joint disease
- Fibromyalgia
- Fractures
- Gastrointestinal conditions (e.g., constipation, ileus, gastritis, gastroesophageal reflux, peptic ulcers)

- Headaches (e.g., temporal arteritis)
- Low-back disorders
- Metabolic conditions (e.g., electrolyte abnormalities, vitamin D deficiency)
- Musculoskeletal disorders
- Neuropathies (e.g., diabetic neuropathy, occipital or trigeminal neuralgia, postherpetic neuralgia)
- Nerve compression
- Oral or dental pathology
- Osteoporosis (compression fractures)
- Peripheral vascular disease
- Post-stroke syndromes
- Pressure ulcers
- Renal conditions (e.g., bladder distension, infection, kidney stones)
- Rheumatoid arthritis
- Sprains, strains, bumps, bruises, skin tears, and other accidental injuries
- Trauma, inflammation, and metastatic infiltration of skin, soft tissues, or bone

Challenges of identifying and managing pain in elderly persons

Residents of long-term care facilities have pain, just as people of all age groups do. What makes pain assessment and management challenging in this setting is that:

- The residents' response to pain and signs and symptoms of pain may differ from that expected of younger adults; signs and symptoms may be atypical for the condition
- Residents may have cognitive and/or communication problems affecting the ability to alert someone to the presence of pain
- Staff members may fail to ask cognitively impaired residents about the presence of pain
- Behavior problems that are usual for the resident may not be associated with pain
- Residents may use different terminology to describe the pain compared with younger persons
- Some residents may not report pain for a variety of reasons
- Assessments, tools, policies, procedures, protocols, and guidelines may be unavailable to assist the staff
- Other illnesses and medications may affect the residents' interpretation of the pain, response to pain, or ability to report pain
- Turnover and staffing problems affect knowledge of each individual resident and time available to observe and assess the residents

- Staff members may be inappropriately trained in recognition, assessment, and management of pain; some nursing schools and textbooks have provided misinformation about pain assessment and management, including promoting the fear of addiction^{4, 5, 6, 7}
- Residents often have several chronic diseases, and the cause of the pain is difficult to identify
- The residents' bodies react differently to drugs compared with that of younger persons; normal aging changes affect how residents metabolize and eliminate drugs, making them much more sensitive to the therapeutic and toxic effects of analgesics and other medications
- Water is a diluent for medications; many long-term care residents have chronic, mild dehydration, and fluid intake may be inadequate

Effects and Results of Pain

Long-term care nurses are very aware of how pain affects the residents, so this information is provided as succinctly as possible. Since pain is an unpleasant sensation, its effects are never positive. Being in pain causes residents to be dissatisfied with the quality of facility care and triggers behavior problems. The effects of unrelieved pain on the body are listed in Figure 1.2.

FIGURE 1.2

EFFECTS OF UNRELIEVED PAIN ON BODY SYSTEMS

Body system	Potential effects of unrelieved pain
Cardiovascular	Increased risk for blood clots/deep vein thrombosis, increased pulse and hypertension, increased myocardial oxygen consumption
Immune	Decreased immune protection, suppressed immune response
Respiratory	Increased oxygen demand, respiratory dysfunction, increased risk for pulmonary embolism, hypoxemia, shallow breathing, inability to expand lungs fully, retained secretions, reduced cough, atelectasis, pneumonia, other infections, confusion due to lack of oxygen
Genitourinary	Fluid retention (kidneys retain sodium and water), decreased output, fluid overload, hypokalemia
Gastrointestinal	Decreased gastrointestinal motility, loss of appetite, weight loss; residents who do not eat often do not consume adequate fluids, resulting in additional complications
Endocrine	Numerous metabolic and hormonal imbalances, glucose intolerance, insulin resistance
Nervous	Sleeplessness, which increases the risk for delirium, exhaustion, and immobility
Cognitive, mental	Anxiety, stress, depression, fear, worry, anger, feelings of hopelessness, difficulty concentrating, confusion, reduced cognitive function, delirium, associated behavior problems, suicidal thoughts, isolation, reduced social interaction
Musculoskeletal	Reduced functional ability, increased dependence, loss of muscle strength and flexibility, increased risk of falls, muscle spasm, impaired muscle function, complaints of muscle fatigue
Integumentary	Poor wound healing
Ongoing	Persistent neuropathic pain and other chronic pain syndromes, reduced quality of life, increased dependence

Pain and Depression

Pain and mood disturbances seem to go hand in hand in older adults. Residents with pain may also have feelings of anxiety, depression, apathy, and sleep disturbance. Fear of the meaning of pain (e.g., worsening of condition, end of life), apprehension, and anxiety can augment the pain response and make coping more difficult. However, avoid thinking that pain is the sole cause of depression and that controlling the pain will eliminate the depression. Depression, if present, must be treated aggressively, or pain management is not likely to be successful. Several studies have shown that investigating the relationship between depression and pain frequently facilitates treatment for both conditions.

Affective/cognitive components

Some residents are treated with psychotropic drugs for behavior problems when the real issue is unrelieved pain. Depression can exacerbate pain and vice versa. The presence of mood disturbances is fairly common and should be included in the comprehensive pain assessment.

The ABC plan of behavior management

Managing behavior is one of the most difficult nursing responsibilities in long-term care. When consistently used, the antecedent/behavior/consequence (ABC) plan is particularly effective. The plan works on the premise that modifying or eliminating the antecedent or consequences of a given behavior problem will modify or stop the behavior.

In this plan:

A = antecedent, or the trigger that causes the behavior

B = behavior, or the action itself

C = consequences, or the results of the behavior

Modifying or eliminating the antecedent or consequences changes the behavior. Figure 1.3 provides an example of the ABC plan in action.

FIGURE 1.3

USING THE ABC PLAN OF BEHAVIOR MANAGEMENT

Situation:

A resident cries, sobs, and complains of pain. She says the medications, environment, and nursing comfort measures are ineffective in relieving her pain. The resident gets so worked up that her daughter comes to visit and sits with her for prolonged periods of time. This is a sacrifice for the daughter, who is unable to tend to her own responsibilities. As long as the daughter is present, the resident remains calm and comfortable. When the daughter leaves, the resident has a marked increase in pain. The daughter's visits are serving as a reward for the pain behavior.

In This Case:

- A = Unknown trigger to pain; a complete assessment and analysis of the pattern may help determine the trigger
- B = Crying, complaining of pain
- C = Prolonged visit from family, emotional support, companionship, hugs, etc.

Outcome:

In this case, the consequences (daughter's visits) are rewarding the behavior.

Using the ABC Plan

Facility staff members should meet with the daughter to develop a plan to modify the consequences of the behavior. Having the daughter visit more often, taking the resident out on day trips, taking her to the spa or beauty shop, or bringing her home are examples of approaches to modify the consequences. Other approaches could be to involve the resident in an activity, get her involved in helping other residents, or having a volunteer visit regularly. The objective is to reward the resident before the behavior starts, eliminating the need for constant attention.

Do not wait until the resident acts out. Implement the plan in advance. If the resident has a behavior outburst, the daughter should resist the temptation to drop everything to come to the facility. (You can expect the resident to test the plan to see whether her behavior will continue to manipulate the daughter.) Implementing the plan consistently before the behavior begins changes the consequences, making the behavior unnecessary.

Joyce Newman, RN, has an expression that she uses daily: “When caregivers interact with a resident in skillful ways, new behavioral symptoms may be caused or existing symptoms may get worse. This kind of interaction is called excess disability.” This means some of the behavioral symptoms the resident shows are caused by the caregivers rather than by the disease or the resident. Make sure your staff is not causing excess disability in residents. Instead, do a little detective work using the ABC plan. Modify the care plan and make sure the plan is used consistently by all staff members. You will be surprised and pleased with the results. Visit <http://tinyurl.com/yazsq6h> to find helpful information on the ABC plan for behavior management.

Other Barriers to Pain Identification and Management

One enlightening study provides a lesson for all of us. The researchers found that one-fourth of facility residents with moderate to severe pain receive no analgesic medications on a daily basis. The reasons given are actually barriers that we can learn from:⁸

- Nurses seldom incorporated formalized pain assessment protocols when they suspected pain. Rather than assessing the residents, nurses used visual and behavioral cues based on their knowledge of each resident.
- Certified nursing assistants did not report pain because their reports were either ignored or resulted in the nurse admonishing the assistant.
- Pain cues were sometimes obfuscated by resident behaviors, family manipulation, attention-getting behavior, attitudes about pain, and fear of addiction.

- Nurses believed the physician was the most important person involved in meeting residents' pain management needs.
- Researchers noted that formal pain assessment protocols were likely to identify pain missed by nurses.

Barriers to effective pain management exist on many levels, including physician, nurse, nursing assistant, resident, family, and environment. Additional barriers to pain identification and management cited in various studies include:

- Denial
- Cultural, religious, and/or social issues
- Racial, ethnic, and gender stereotyping and biases
- Cognitive impairment
- Fear
- Shame
- Misperceptions
- Belief that pain is a normal aging change
- Language barriers
- Other communication barriers, such as aphasia
- Myths and misinformation about pain

- Family or staff attitude
- Semantics; residents use different words to describe pain
- No specific cause for pain ever identified
- Inadequate communication
- Breakdown in the continuity of care
- Lack of commitment to pain management
- Environmental problems
- Nonspecific symptoms
- Atypical pain response
- Coexisting illnesses and multiple medication use affecting the ability to interpret or report pain
- Multiple medications affecting residents' pain response
- Concern about side effects
- Comorbidities
- Staff knowledge, skill, and training deficits
- Misunderstanding about analgesics, including opioids
- Lack of proper assessment tools

- Lack of time
- Nurses disbelieve resident complaints
- Residents do not have visible signs of pain
- Workload, turnover, and staffing issues
- Staff members are desensitized to residents with pain
- Belief that pain treatment is unnecessary in light of adequate function
- Belief that persistent pain has little potential for change
- Fear of functional dependence
- Physicians underprescribe medications

Quality of Life

In addition to the obvious discomfort, the effect of pain on quality of life can be profound. Because of this, the federal government made extensive changes to the survey requirements for Quality of Life (F309) in 2009. Before this, discussion of pain and pain management in the regulations was minimal. The information was expanded to 38 pages, so review it carefully. Prior to the 2009 changes, facilities were expected to manage pain but had few guidelines to go by. However, since pain has a profound effect on residents' lives, deficiencies may potentially be cited under many survey tags, so nurses should consider all of these. These are listed in Figure 1.4. You will find additional information on regulatory compliance in Chapter 9.

FIGURE 1.4

POTENTIAL SURVEY TAGS RELATED TO PAIN

Pain:

Assessment and problem recognition—F-tags: 272 (assessment) and 309 (quality of care)

Diagnosis and cause identification—F-tags: 272 (assessment), 385 (physician services), and 386 (physician review of total plan of care)

Care plan, treatment, and management—F-tags: 279/280 (comprehensive care plans), 309 (quality of care), and 386 (physician review of total plan of care)

Monitoring—F-tags: 272 (assessment), 309 (quality of care), and 329 (unnecessary drugs)

End-of-Life Care:

Assessment and problem recognition—F-tags: 272 (assessment) and 309 (quality of care)

Treatment and problem management—F-tags: 279/280 (comprehensive care plans), 309 (quality of care)

Monitoring—F-tags: 279/280 (comprehensive plans) and 309 (quality of care)

See Chapter 9 for more information.

Note: You can download a complete table of these tags and potential quality improvement and survey probes from www.michigan.gov/documents/cis_bhs_fhs_checklists_37050_7_89950_7.pdf. The federal long-term care facility rules may be downloaded from the Centers for Medicare & Medicaid Services' *State Operations Manual* at www.cms.hhs.gov/Manuals/IOM/list.asp. Refer to appendix PP.

Nursing Responsibilities

The standards of care that all nurses must adhere to include advocating for the residents and:

- Acknowledging and accepting the resident's pain
- Assessing the resident to identify the most likely cause of the pain

- Regularly assessing pain, including new reports of pain or at any time medication has been given, as well as whenever pain is likely to recur
- Using an accepted pain assessment tool
- Identifying potential barriers to effective pain management
- Documenting and reporting the resident's pain accurately and in a timely manner
- Developing a plan of care for effective pain management
- Implementing pain management strategies
- Assessing and managing side effects, if they occur
- Dispelling myths and reinforcing/teaching facts
- Teaching subordinate staff members, the resident, and appropriate family members and/or significant others regarding:
 - Their role and responsibilities in pain management
 - The consequences and adverse effects of unrelieved pain
 - How to overcome barriers to effective pain management
 - The resident's individual pain management plans and expected outcome
- Evaluating the effectiveness of the plan of care
- Documenting and reporting the interventions, resident's response, and outcomes

In order to do these things, the nurse must seek out and learn accurate, current information about pain.

What Matters

The nursing boards in several states have specific standards and competencies related to pain assessment and management. Some have mandated continuing education classes on pain management as a requirement for license renewal. Check your licensure board to determine whether your state has specific requirements. However, nurses advocate for the individuals in their care. One of the ways you do this is by assessing for and managing pain.

As nurses, our primary responsibility is to relieve pain and suffering. This is why you became a nurse, and no one should have to tell you to support this key nursing intervention. Pain, like irritability of the brain, perpetuates and intensifies itself.⁹ The Nightingale Pledge says, “I will do all in my power to maintain and elevate the standard of my profession.”¹⁰ This pledge is recited by practical and registered nurses during the pinning or graduation ceremony in many schools. It was written in 1893 in honor of Florence Nightingale and was considered the first nursing Code of Ethics. Long-term care personnel are legally and ethically obligated to provide care that meets or exceeds minimum accepted standards of care. Applicable standards of practice for long-term care professionals include but are not limited to the following:

- Every patient should be assessed for pain systematically and regularly. It is essential to always try to treat persistent pain, even when health-care practitioners cannot identify a specific cause for the pain.¹¹
- When making clinical judgments, nurses must base their decisions on consideration of consequences, which prescribe and justify nursing actions. The recipients of professional nursing services are entitled to high-quality nursing care.¹²

- Gerontological nursing practice involves assessing the health and functional status of aging adults, planning and providing appropriate nursing and other healthcare services, and evaluating the effectiveness of such care. Emphasis is placed on maximizing functional ability in ADLs; promoting, maintaining, and restoring health; preventing and minimizing disabilities of acute and chronic illness; and maintaining life in dignity and comfort until death.¹³
- The LP/LVN shall have a personal commitment to fulfill the legal responsibilities inherent in good nursing practice.¹⁴
- Caring behaviors are nurturing, protective, compassionate, and person-centered. Caring creates an environment of hope and trust. The LP/LVN demonstrates a caring and empathic approach to the safe, therapeutic, and individualized care of each client. The LP/LVN assists the client to achieve optimum comfort and functioning.¹⁵
- The healthcare administrator maintains the quality of resident care, resident rights, and efficiency of services.¹⁶
- Individuals shall hold paramount the welfare of persons for whom care is provided. The healthcare administrator shall strive to provide to all those entrusted to his or her care the highest quality of appropriate services possible.¹⁷

The standards for identifying and managing pain are not new. Recent refinements in long-term care facility rules defined and explained existing information, giving facilities guidelines to follow. The point here is to recognize that what matters is that nurses recognize that they are legally, ethically, and

morally bound to identifying and managing pain in the residents in their care. Knowing the etiology of the pain helps the physician identify the most effective treatment. From the nursing perspective, knowing the etiology of the pain is helpful but not essential. If a resident is in pain, your responsibility is to help make him or her more comfortable. Administering medication is only one of many approaches that may be used. Assisting you in this mission is a primary goal of this book.

Establishing a Pain Management Program

All residents have the right to appropriate pain assessment and management. A facility-wide commitment to effective pain management is essential for regulatory compliance and ensuring quality of life. To establish a viable pain management program in your facility or on your unit:

- Develop a personal commitment to ensuring resident comfort
- Motivate yourself and your staff and keep the momentum going
- Review and study your current pain management practices and identify positive and negative practices in the current program
- Develop a team of staff members from all levels (e.g., nursing assistant, LP/LVN, RN, resident) to assemble a realistic pain management program
- Implement the positives from your existing program
- Identify methods of correcting the negatives
- Establish standards for pain management in your facility or on your unit

- Review and update your written policies and procedures associated with pain management
- Educate staff members on their roles and responsibilities
- Implement the program
- Hold regular pain team meetings to monitor and fine-tune the plan

It Takes a Village

“It takes a village to raise a child” has an analogy in long-term care. We need each other, and the residents need all of us. Together we constitute a village. Effective pain management is not limited to the nursing department. The services and expertise of the entire interdisciplinary team of professionals and paraprofessionals are needed to provide a holistic pain management program for the residents. For the pain management program to be effective, facility management must make a sincere commitment to making it work. Policies, procedures, guidelines, and resources must be available. Realistic goals must be established. Education for caregivers at all levels is integral to success. Ensure that staff members are competent in pain assessment and management and add information to the orientation program for new clinical staff members. Provide resident and family education, but remember that education alone will not produce the desired results. The commitment to pain management must be evident and noticeable, and staff members must be held accountable for their performance.

Staff members must be familiar with myths, facts, and barriers to effective pain management, including their own attitudes. Communication must be regular,

open, and accurate. Documentation must be concise. Use of the nursing process is essential. Benchmarks must be identified, and a means of measuring outcomes must be developed.

Change is inevitable, growth is optional

Although change is inevitable, growth is optional. Motivate staff members to grow and rethink the strategies they use in resident care. For example, when a resident experiences a behavior problem, the nurse's first consideration is often whether to use a restraint or administer a medication to manage behavior. A better initial action is to determine whether pain is causing the behavior outburst. If the cause cannot be identified, giving a mild analgesic and evaluating the response is much safer than giving an antianxiety or psychotropic drug.

Under normal circumstances, facility workers have a high degree of self-confidence and autonomy that have developed over time by making decisions and performing routine tasks at work each day. Because of this, workers usually feel secure in their jobs and project an image of competency and confidence. Change is risky. It is always an unknown, and entering unknown terrain is threatening. Change may unmask an image problem, reveal a weakness, expose deficits, and/or result in personal or professional failure. Resisting and avoiding change is easier for some employees than risking failure or criticism. Giving them ownership in the pain management plan and soliciting their advice makes it less likely that the plan will fail. This is true for employees at all levels, from the nursing assistants to nursing managers.

Transformation

Implementing a pain management program requires a commitment. When it comes down to the bottom line, this is about the residents. It is not to make

your jobs easier or to keep surveyors happy. Transformation always requires a redefinition of who we are and what we do. This causes an emotional reaction to change. Staff members may have to respond to unforeseen circumstances, which is stressful and often unnerving. To successfully lead your subordinates through this change, give meaning to the change. This is true whether you are the director of nursing or a charge nurse on a unit. Provide a vision of what the pain management program will look like, and inspire your staff to attain the vision. An effective program makes jobs easier and improves the quality of residents' lives.

As a rule, change is much more acceptable and manageable if residents and employees have some control over the variables associated with the change. Managers at all levels must educate and motivate their subordinates, but they cannot force change. The motivation to change is ultimately internal, and each employee must accept responsibility for changing. Dedicated staff members want the best for the residents. Well-run facilities that are committed to relieving pain often find they have less pain than they did previously because staff members are paying attention. The workers are empowered, which makes them good team players who have less stress and greater job satisfaction.

Empower employees to make a pain management program work. Involve them in planning and evaluating care. In addition to benefitting the residents, it is an effective means of sharing employee skills and knowledge of the residents. You will find tools and tips to help you accomplish your goal throughout this book.

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