

ASSESSMENT AND MANAGEMENT OF CHRONIC PAIN IN THE OLDER PERSON LIVING IN THE COMMUNITY

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Accepted for publication December 2005

Key words: Chronic pain, older people, domiciliary/home/community care nurses, pain assessment, pain instruments

ABSTRACT

Aim:

This paper reviews the nursing research literature on chronic pain in the older person living in the community and suggests areas for future research.

Background:

Chronic pain is a pervasive and complex problem that is difficult to treat appropriately. Nurses managing chronic pain in older people in domiciliary/home/community nursing settings face many challenges. To provide care, the many parameters of chronic pain which include the physical as well as the psycho-social impact and the effect of pain on patients and their families, must be carefully assessed. Beliefs of the older person about pain and pain management are also important.

Method:

Relevant nursing studies were searched using CINAHL, Cochrane Database of Systematic Reviews, EMBASE and PUBMED databases using key words about pain and the older person that were appropriate to each database.

Results:

Tools to assess pain intensity in the older person have been studied but there has been less research on the other parameters of pain assessment or how the older person manages pain. An effective nurse-patient relationship is an important component of this process and one that needs more study. Few research studies have focused on how nurses can be assisted, or on the challenges, nurses' face, when managing this vulnerable population.

Conclusion:

A broad approach at the organisational level will assist nurses to manage this health care issue.

Acknowledgement:

I would like to acknowledge the assistance of Paula Tognazzini, MSN Instructor and Post RN Advisor,

University of British Columbia School of Nursing and Kathy Gregg, MSc and Clarissa Tsang BSN, Research Assistants in the preparation of this manuscript.

INTRODUCTION

Chronic pain is a significant health problem for older people living in the community. The prevalence rate is difficult to determine but researchers in Australia and overseas have found between 27% (Blyth et al 2001) and 51% (Helme and Gibson 1997) of those over 65 years report chronic pain. In those 85 years and older, the prevalence rates are higher as researchers report that as many as 70% of older persons who live in community settings report pain (Brochet et al 1998; Roy and Thomas 1987; Scudds and Robertson 2000). This high prevalence is a concern as chronic pain, particularly in the older person, is not well-treated (Ferrell et al 1990; Pitkala et al 2002).

Chronic pain affects all aspects of an individual's life and has a major impact on health services. A Canadian study reported over 75.7% of older people receiving home nursing had been troubled by pain in the past two weeks (Ross and Crook 1998). Managing chronic pain in the older person is an important nursing responsibility; however, most research that guides nursing practice has been conducted in acute care or nursing home settings. Nursing research about managing chronic non-malignant pain in non-institutionalised older persons is limited.

The purpose of this paper is to review the nursing literature on assessment and management of chronic pain in older persons in a community setting and to suggest areas for further research.

Relevant nursing studies, in English, were searched in electronic databases up to July 2005. Neoplasms and palliative care studies were excluded and a limit of age 65 and older imposed. Databases included: CINAHL (1982-) using keywords: aged, chronic pain, community health nursing; Cochrane Database of Systematic Review combined aged, chronic pain, community care with complementary and alternative medicine; EMBASE (1996 -) using keywords aged, chronic pain and home services; PUBMED (1967-) using MeSH terms: aged, pain, pain assessment, home care services.

LITERATURE REVIEW

Assessment of chronic pain

Pain assessment in the older person is particularly complex because of other underlying health issues, polypharmacy, and increased sensitivity to pain-relieving medications. A range of other factors such as the patient's beliefs and attitudes toward pain and analgesic medications, health professionals' lack of knowledge and lack of understanding about the complexity of chronic pain, and even organisational barriers, add to the problem and complicate the nurse's role. Chronic pain affects all dimensions of an individual's life: physical; psychological; social; and spiritual, and data should be gathered on all these aspects as well as the meaning of pain for the individual.

Chronic pain can interfere with the older person's abilities to perform activities of daily living (ADLs). In domiciliary/home/community care settings, researchers have found that older people with chronic pain require more assistance with ADLs from domiciliary/home/community care nurses than those who are pain free (Ross and Crook 1998). Chronic pain can also affect appetite (Bosley et al 2004) and sleep (Ferrell et al 1990; Ross and Crook 1998).

Researchers in other fields have noted that pain intensity has the most impact on the older person's physical functioning, but other pain characteristics which include location, onset, duration, frequency, and pattern (continuous or intermittent) also have an effect. For example, pain that is continuous but of moderate intensity can be just as disabling as severe pain that is intermittent (Lichtenstein et al 1998). (Disability is defined as difficulty performing three or more activities of daily living). Level of disability also increases if more than one body site is affected (Lichtenstein et al 1998). Falls in the older person have also been linked to chronic pain (see Varela-Burstein and Miller 2003 for a review), and although all the particulars of the association are not clearly understood, it is postulated that pain may cause individuals to modify their ADLs. These modifications can lead to problems of balance and loss of physical conditioning which can predispose to falls. Pharmacotherapy used for sleep and for pain relief may contribute to falls also.

In the older population, nursing investigators have focused on which tools measure pain intensity accurately. In community settings, assessment tools have been studied to determine if some instruments are too abstract, particularly when cognition is a problem. The following tools have been researched using older persons in community settings as the population: verbal descriptor scales (VDS) (Benesh et al 1997; Herr et al 2004; Taylor and Herr 2003); the vertical visual analogue scale VAS [v-VAS] (Benesh et al 1997; Herr et al 2004); temperature scales (PT) (Benesh et al 1997; Taylor and Herr 2003); numerical rating scales (NRS) (Benesh et al 1997; Taylor

and Herr 2003; Herr et al 2004); verbal numerical rating scale (VNS) (Herr et al 2004); and faces pain scales (FPS) (Herr et al 1998; Herr et al 2004; Taylor and Herr 2003). Several researchers have concluded that these commonly used tools are valid and reliable for older persons, and many are suitable for those with mild to moderate cognitive impairment (Ferrell et al 1995; Taylor and Herr 2003) if special provisions such as enlarged print and careful explanations are made (Taylor and Herr 2003).

There is less research on assessing the impact of chronic pain on the psychosocial well-being of the older person living in the community. Chronic pain can interfere with the older person's ability to shop, maintain their home and with family and social relationships (Ross and Crook 1998; Mobily et al 1994). The risk of depression increases with chronic pain (Carrington Reid et al 2003; Lin and Taylor 1999; Ross and Crook 1998). Because some of the symptoms of depression and chronic pain are similar, nurses may need to use a mental status questionnaire such as the Mini-Mental Status Questionnaire (Folstein et al 1975) in conjunction with pain assessment measures to ensure that the patient receives appropriate care (Herr and Mobily 1991). Cognition can be influenced by both pain and analgesics (McCaffery and Pasero 1999).

One of the difficulties associated with pain assessment is that the older person may be reluctant to report pain. Clinicians have suggested that stoic attitudes, fears of aging, fears about medications, fears that pain means they may not recover, are commonly held beliefs about pain and pain management (Ferrell et al 1990; Herr and Mobily 1991; Muonio 2004). Investigators in long-term care settings suggest that the older person may not want to bother nurses and believe that complaining may alienate health professionals and drive away their limited social support (Ferrell et al 1990; Yates et al 1995). Conversely, some clinicians suggest that older persons may report pain instead of other symptoms as pain is more acceptable to report than physical losses, loneliness and boredom (Herr and Mobily 1991).

The language used by older persons to describe their pain may differ, as they may not refer to a problem as pain but instead use terms like soreness or annoying (Miaskowski 2000). Obtaining accurate pain reports from those with dementia is a concern.

Mäntyselka et al (2004) found that the older person with dementia living in the community, as assessed by a geriatrician, reported less pain and used less analgesics than those who did not have dementia. This suggests that although persons with dementia do not report as much pain, nurses need to use other means to assess pain and provide pain relief.

Management of chronic pain

Recently there has been more attention to the investigation of the older persons' beliefs about pain and

about their preferred methods of managing it (Jakobsson et al 2003; Ruzicka 1998; Tse et al 2005; Walker et al 1990; Yates et al 1995). Ruzicka (1998) found a diversity of beliefs about causes of pain and pain management as some older persons view pain as something that they have some control over and others believe that pain management requires assistance. This researcher also found that older persons believe that being anxious or depressed increases pain (Ruzicka, 1998). Walker et al. (1990) found that comprehensive data should be gathered on the older person's understanding of the cause of pain, methods used for pain control, as well as past life regrets, how busy or occupied they are, and any personal problems experienced, as these factors have a significant impact on the patient's ability to remain in control and cope with chronic pain.

Chronic pain may require a combination of methods to manage it successfully and older people prefer some methods to others. Swedish researchers found that on average, older people used only three different methods and, amongst those living at home, the most frequently used methods were prescribed medication, rest and distraction (Jakobsson et al 2003). However, their preferred strategy varied with their living situation (Jakobsson et al 2003) as those who lived alone preferred exercise above prescribed medications whereas those living with someone preferred to use heat above prescribed medications.

Older persons may rely on, and even prefer, self-care techniques such as home remedies, massage, non-prescription analgesics, and cognitive techniques such as distraction and rest to pain-relieving medications, exercises or physiotherapy (Jakobsson et al 2003; Landsbury 2000; Tse et al 2005). More investigation is needed into the approaches used by older persons and their preferred strategies particularly as older persons are frequently taking multiple prescription medications.

Cognitive strategies used by older people living in the community have not been investigated in depth. Dunn and Horgas (2004) found that behavioral coping strategies which included reporting pain to physicians or nurses were used more frequently than cognitive coping strategies such as self-statements. Religious coping strategies were used by older women and older persons of minority groups (Dunn and Horgas 2004). Ersek et al (2003) found that a self-management chronic pain program can have a significant positive impact on the older person's pain intensity and ability to perform work and daily activities. However, access to these programs may be an issue for the fragile older person.

Research indicates clearly that having a supportive individual to talk to about pain is important to the older person (Dunn and Horgas 2004; Jakobsson et al 2003; Walker et al 1990; Yates et al 1995). Older patients expect and want nurses to provide support, and discuss pain issues (Dunn and Horgas 2004; Walker et al 1990).

Emotional support is as important to patients as advice on prescribed treatments (Walker et al 1990).

Nursing issues in assessment and management of chronic pain

Researchers have also suggested that factors in health professionals are associated with poor pain assessment and management. McCaffery's landmark work in the 1960's encouraged health professionals to believe that pain was what the patient's says it is (McCaffery 1968). However, there is evidence that health professionals place their own interpretation on the patient's pain. Research from domiciliary/home/community care (Hall-Lord et al 1999) and long term care settings (Katsma and Souza 2000) indicates that health care professionals underestimate pain in the older person. Walker et al (1990) found that the long-term contact with the older patient that occurs in domiciliary/home/community care settings, did not positively influence the nurse's estimates of patient's pain.

Lack of knowledge of pain is often cited as a major reason why nurses do not manage pain adequately in older persons (see Brown 2004 for a review; Brockopp et al 1993; Clarke et al 1996; Closs 1996; Watt-Watson 1987). Most of this research has been done in acute care settings but domiciliary/home/community care nurses have identified that they need more knowledge about chronic pain management, management of patients' co-morbid conditions and pharmacology to manage the older person's pain adequately (Glajchen and Bookbinder 2001; Kee and Epps 2001; Laborde and Texidor 1996; Törnkvist et al 1998). Glajchen and Bookbinder (2001) noted that the nurses may not be aware that their pain management knowledge base is inadequate and may overestimate what they know. More systematic exploration of the problems that nurses encounter and the strategies that nurses use to manage these problems is urgently needed.

Research with older persons in the community has tried to determine if various patient characteristics (age, gender, marital status and culture) influence nurses' pain assessments. Hall-Lord et al (1999) found that the patient's marital status has some influence as enrolled nurses (LPN's) overestimated pain in married patients, and underestimated pain in single patients (Hall-Lord et al 1999). These researchers suggest that spouses may make the nurses more aware of the patient's pain and thus increase the nurses' ratings of patients' pain. Culture influences the way patients express pain and how nurses assess and manage it (Bell and Reeves 1999; Duggleby 2003; Lasch 2000). There is a lack of research about the cultural aspects of chronic pain in older persons and further investigation is needed as this population may face further disadvantage by having language problems as well.

Researchers have suggested that nurses' attitudes and beliefs as well as lack of knowledge may influence how nurses assess pain and provide analgesia (Clarke et al 1996; Edwards et al 2001; Hamilton and Edgar 1992).

The relationship between knowledge and attitudes in domiciliary/home/community care settings has had only minimal investigation, however Laborde and Texidor (1996) indicated that knowledge had a positive influence on domiciliary/home/community care nurses' attitudes about chronic pain management.

Investigations into nursing interventions used to manage chronic pain in domiciliary/home/community nursing settings are limited. Walker et al (1990) found that nursing interventions that help patients achieve control over their pain are helpful. Therapeutic touch significantly reduced musculoskeletal pain and anxiety in an older population (Lin and Gill Taylor 1999). McCaffrey and Freeman (2003) used a randomized control trial to determine that music therapy reduced pain levels of community-based patients with osteoarthritis. Patient education has a role in pain management.

Research with cancer populations in home nursing settings identified that structured educational interventions helped patients and families cope with cancer pain (Ferrell et al 1998) and reduced home care nursing cancer patients' barriers to reporting pain and using analgesia (Chang et al 2002). Further investigation of the particular educational needs of older persons and their families with non-malignant pain would add to our knowledge in this field.

Patients receiving nursing care at home expect nurses to advocate with physicians for their pain management (Ferrell and Dean 1994; Walker et al 1990). Laborde and Texidor (1996) found that domiciliary/home/community nurses regard the physician as the prime source of knowledge about pain management. Investigators have found that many general practitioners find managing chronic pain a challenge (Blum et al 1990; Weinstein et al 2000), thus nurses need access to expertise in pain management such as pain specialists, clinical nurse specialists and interdisciplinary pain management programs. Often interdisciplinary pain management programs exclude older persons because of an age bias and a goal to rehabilitate those who can return to work. An Australian study established that the geriatric population can benefit from these clinics (Helme et al 1996). One American study found that domiciliary/home/community nurses do not make use of these clinics/centres even as sources of advice to help patients with chronic pain (Laborde and Texidor 1996).

Organisational culture and management structures are crucial to pain management, but research on their contribution is limited. Organisations that manage pain successfully use a multiple pronged approach which includes protocols, policies and assessment practices (Ferrell 1995; Weissman et al 2000) as well as a long-term commitment to education. In the community, when nurse pain-advisors were introduced as resource persons, nurses found that their assessment, evaluation and documentation of pain in patients with leg ulcers improved (Törnkvist et al 2003). This low-cost management strategy also increased the nurses' satisfaction with their care.

SUMMARY AND CONCLUSIONS

There is an urgent need for more research about how nurses care for the older person with pain in community settings. A major research focus has been to determine which tools are appropriate to measure pain intensity. Although pain intensity is an important basis for treatment, other factors also affect pain assessment and management. These factors include the impact of other pain characteristics on the individual's physical and psychosocial functioning. The effect of co-morbid conditions and the influence of patient and nurse characteristics are also important influences on pain assessment and management. The nurse-patient relationship is crucial but this relationship has not received much attention in pain management research. Non-invasive nursing interventions also need more exploration.

The beliefs, concerns, and practices of older persons about pain also have a major impact on pain management. Interventions that assist older persons to develop and retain control of their pain management have improved outcomes but more investigation is required into these areas. As the rate of depression amongst older persons is high and can contribute to other physical symptoms such as decreased mobility and limited social interaction, it is critical that the psychosocial needs of older persons with chronic pain be assessed. These patients are often isolated and the nurse may be one of their few contacts, hence the nurses' abilities to assess for and differentiate between pain and depression and to advocate for care are critical.

Research-based information on the nurses' needs and the challenges they face when managing chronic pain in the home is extremely limited. The lack of evidence-based information is even more significant given that nurses' responsibilities for managing this complex health problem have increased. From the exploration that has been done, nurses need education tailored to address their specific knowledge needs about pain, co-morbid health conditions, pharmacology and appropriate methods of educating older patients and their families. Access to expert advice such as clinical nurse specialists and avenues of referral to specialised pain management programs are also required along with organisational structures such as policies, procedures and resources to address pain. A multifactorial approach at all levels is crucial. Given the high prevalence of chronic pain in this population, and the impact upon patients, families and the health care system this health care problem needs to be addressed.

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