Pain Management in Long-Term Care: Update on Guidelines and JCAHO Standards

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Chronic pain is expensive—not only economically, but in the loss of pleasure and the ability to lead a normal productive life—and it only gets worse with age. New research promises that new guidelines for pain management will become available. Awareness of the current guidelines aids elder law practitioners in advising clients about their apparent circumstances and needs.

By Jayne E. Pawasauskas and Andrea F. Luisi

Chronic pain is the most expensive health problem in the United States, costing about $65 billion annually. The costs are due to direct medical expenses, lost income, lost productivity, and legal charges. This is not surprising, since unrelied chronic pain can have serious consequences, such as the development of depression, decreased socialization, sleep disturbances, impaired ambulation, and increased health care costs and utilization. Many other conditions may potentially be worsened by the presence of pain, such as gait disturbances, progress of rehabilitation, deconditioning, polypharmacy, cognitive dysfunction, and malnutrition.

Careful attention must be given to the identification and assessment of pain, especially in the elderly population, since chronic pain is a common finding. Older people are more likely to be affected by arthritis, bone and joint disorders, back problems, and various other chronic conditions that cause pain.

Fortunately, the issue of pain management has been drawing much attention in the recent years. Newer guidelines have been published that address many aspects of pain management, from initial assessment through long-term follow-up.

American Geriatrics Society
In 1998, the American Geriatrics Society (AGS) published a consensus statement regarding pain management guidelines for the elderly. These
ARTICLE | Pain Management in Long-Term Care

guidelines specifically address the management of chronic, noncancer pain in older persons. Such a paper was needed because prior to its publication, there were no comprehensive recommendations from such a large panel of experts. The AGS tried to avoid duplicating past efforts and, as a result, has created a very useful guide for anyone faced with the challenge of managing chronic pain in an older person.

One of the most important issues addressed by the AGS guidelines is that of assessing pain in the elderly. Older patients should be assessed for evidence of chronic pain whenever they present to a health care service. When assessing pain, it is important to bear in mind that older patients may use descriptors such as “gnawing,” or “aching,” rather than using the actual word “pain.” For this reason, a variety of descriptors synonymous with pain should be used.

It is imperative that the clinician that assesses an older patient for pain acknowledges potential barriers to effective pain management. Barriers that are specific to older patients include reluctance to report pain despite an impact on function, fear of the significance of pain, fear of the medications used to treat pain, or the belief that pain is a punishment for some wrongdoing.

If a clinician believes that some of these barriers are present, he or she should seek assistance from the appropriate health care professional to address the issue. For example, a patient who is fearful of the side effects of an analgesic medication will likely benefit from speaking with a physician or pharmacist. In such instances, the long-term care setting offers an ideal environment for disease-state management because long-term care facilities are required to utilize an interdisciplinary approach to patient care.

The AGS guidelines also address pharmacological issues relevant to the elderly population. Older patients are more likely to experience adverse drug events; however, this fact should not prohibit the use of analgesic or adjuvant medications in elderly patients. The elderly can safely use most medications when started at lower doses that are then slowly increased to reach the effective dosage.

Pharmacotherapeutic strategies are most effective when combined with nonpharmacological treatments. Furthermore, it may be advantageous to use a combination of low doses of analgesic agents from different drug classes, rather than using high doses of one single agent. An example of this would be the use of an opioid with a non-steroidal anti-inflammatory agent (NSAID). This use of multiple medications to achieve the same therapeutic endpoint, or polypharmacy, is a practice that most clinicians usually try to avoid. However, polypharmacy may be necessary to minimize the side effects of individual agents.

The majority of pain management guidelines will recommend utilizing the World Health Organization (WHO) analgesic ladder. This is a stepwise approach to pain management that utilizes a 3-step ladder of increasing analgesia. The first step of the ladder recommends using non-opioid analgesics, such as acetaminophen or NSAIDs, with or without the use of adjuvant medications, such as corticosteroids or antidepressants.

The use of NSAIDs in the elderly is of paramount concern. The chronic use of NSAIDs in the elderly has been associated with a high incidence of adverse effects. The risk of gastrointestinal bleeding associated with NSAID use increases with age. The AGS guidelines recommend extreme caution when using NSAIDs in the elderly. In fact, the AGS recommends avoiding high-dose, long-term NSAID use in the elderly. When NSAIDs must be used chronically, it is recommended that they be given as needed, rather than scheduled daily or around-the-clock. This concept differs from one of the basics of managing chronic pain. That is, when treating chronic pain, the intention is to prevent pain, not chase it. However, when considering the risks of chronic NSAID use in the elderly, the risks may outweigh the benefits, and alternative non-opioid medications may be more appropriate.

Acetaminophen is considered the drug of choice for managing mild to moderate musculoskeletal pain. Acetaminophen, however, also has properties that must be taken into consideration when it is prescribed. The main concern with the use of acetaminophen is the potential for liver toxicity. This concern limits the maximum daily dose to 4 grams. Clinicians must remember that certain opioid medications are combination products containing acetaminophen (e.g., Vicodin®, Percocet®), and must not dose the opioid/non-opioid combination product in a way that would exceed the 4-gram per day acetaminophen limit.

The use of opioids in noncancer pain has been a controversial topic. Nevertheless, patients should receive adequate analgesia regardless of their diag-
noses. The doses of opioid analgesics needed for managing chronic pain that is noncancer related are often lower than those needed for managing cancer-related pain.

Adjuvant medications may be helpful for managing chronic pain that is neuropathic in quality, in addition to the use of analgesic medications. Adjuvant medications that are commonly used include antidepressants, anticonvulsants, antiarrhythmics, and various others. Many drugs from each of these classes can safely be used in the elderly, provided that attention is given to monitoring for side effects. Of particular interest is the class of antidepressants.

The antidepressants most commonly used for managing pain are amitriptyline, nortriptyline, imipramine, and desipramine. All have similar analgesic effects, however each has a very different side-effect profile. For example, amitriptyline is converted in the body to nortriptyline. Both have the same analgesic potential, however, amitriptyline is associated with more pronounced anticholinergic effects (dry mouth, constipation, sedation). As a result, amitriptyline is not recommended for use in the elderly, and nortriptyline can be used in its place.

American Medical Director's Association
In 1999, the American Medical Director's Association (AMDA) published a clinical practice guideline for the management of chronic pain in the long-term care setting. The guideline was developed by an interdisciplinary team utilizing evidence-based and consensus-based medicine. One of the goals of the AMDA was to promote responsible and competent physician practices within the long-term care setting. Similar to the AGS guideline, this publication focuses on many aspects of the management of chronic pain.

Firstly, the AMDA stresses the importance of recognizing the barriers to identifying chronic pain in the long-term care setting. Such barriers include blunted responses to pain, cognitive and communication barriers, cultural and social barriers, coexisting illnesses and multiple medication use, staff training and access to appropriate tools, and system-related barriers.

Managing pain for cognitively impaired patients presents a considerable challenge. Such patients have been found to be at higher risk for the undertreatment of pain. Furthermore, patients may be diagnosed with a mood or thought disorder and consequently treated with psychotropic medication when their real problem is unrecognized and untreated pain. Clinicians should also realize that a specific cause of the chronic pain might not be identifiable. The AMDA states that pain must always be treated, even when its cause is not known.

Secondly, the AMDA presents a stepwise approach for pain management. The first step involves identifying pain. Use of the Minimum Data Set (MDS) is proposed as a tool for identifying the presence of pain. In addition to the section of the MDS that specifically addresses pain, other sections may identify nonverbal signs of pain. These may include sleep cycle disruptions; sad, apathetic, or anxious appearance; change in mood; change in behavior; functional limitations; change in activities of daily living function; weight loss; or change in sense of initiative or involvement, to name a few.

The next step in providing pain management, as outlined by the AMDA, involves the actual provision of treatment. This involves taking a comprehensive history and performing a physical exam, including further diagnostic testing if necessary. It also is recommended to obtain consults from any pertinent services and to utilize an interdisciplinary approach when designing the resident’s care plan.

The recommendations for use of analgesic agents are very similar to those of the AGS; however, the AMDA lists certain medications that should be avoided in long-term care residents. Such agents include indomethacin, piroxicam, tolmetin, meclofenamate, propoxyphene, meperidine, pentazocine, and butorphanol. Use of these medications is not recommended due to the increased incidence of adverse reactions without additional therapeutic benefit over other, more appropriate agents.

Lastly, pain should be assessed at regular intervals or, at minimum, whenever a change in condition prompts a new MDS to be completed.

Joint Commission on Accreditation of Healthcare Organizations
In addition to these updated guidelines, standards of patient care have been updated, with a new focus on pain management. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) updated its standards for accreditation in 1999. The issue of pain management was addressed for ambulatory patient care, behavioral health care, home care, health care networks, hos-
hospital, long-term care, and long-term care pharmacies. These standards will appear in the 2000–2001 accreditation standards manuals, and facilities will first be assessed for implementation of these standards in 2001. The updated standards create new expectations for the assessment and management of pain with a focus on patient goals and rights.

Of particular interest are the standards for the long-term care setting. The first topic addressed is that of the residents’ rights and ethical issues involved in providing care. Long-term care facilities must address the effective management of pain by including the resident when making decisions regarding care. An example of how this might be implemented would be for a facility to include a commitment to pain management in its resident bill of rights. It is also acceptable to expect the residents to assist in this commitment to pain management by being actively involved in the management process. This includes asking what to expect regarding pain management, discussing therapeutic options with health care providers, working with the providers to develop a pain management plan, asking for pain-relief intervention when pain first begins, helping the staff to assess pain, and notifying the staff if the pain is not relieved.

JCAHO has also set the standard that all residents have the right to appropriate assessment and management of pain. Long-term care facilities must plan, support, and coordinate activities and resources to assure that pain of any resident is recognized and addressed appropriately. This includes the initial assessment and regular reassessment of pain, the education of providers in pain management, the education of the residents and their families, the management of pain and the side effects of pain treatments, and the consideration of personal, cultural, spiritual, and ethnic beliefs that may impact care. For example, pain could be considered the “fifth” vital sign, where pain ratings are recorded with temperature, pulse, respiration, and blood pressure. Many facilities have already adopted this approach to pain assessment and documentation.

Long-term care facilities must prepare for continuity of care after discharge and help the resident and the family to adapt to the resident’s care plan. Discharge planning must address several areas of patient care; however, the new standards direct attention to the management of symptoms, such as pain or nausea. The resident should have a discharge regimen addressing symptoms that is practical for that resident and his or her caregiver.

One very important standard of the JCAHO guidelines is the concept of providing individualized care. With regard to pain management, there are now resources that help guide the decision-making process or present pain management in a protocol or pathway format. Pain is one of the most subjective disease states, requiring great attention to the resident’s reports and complaints. There are no objective biologic markers for pain, especially for chronic pain. Furthermore, there are several different published tools for assessing pain. However, it’s important to recognize that individual patients will require, or prefer, to use specific tools. For example, one patient may not be able to use a visual analogue scale and may prefer a numerical rating scale instead. Yet another patient may prefer the “smiling faces” scale. It may not be reasonable to select one or two scales and expect every resident in a given facility to be able to use them.

Lastly, long-term care facilities must educate residents to the concept that pain management is a part of their treatment. Residents and family members should be instructed about pain, the risk of pain, and the importance of pain management. For example, the facility could provide information to all residents and families about pain at the time of admission. The JCAHO standards also provide suggestions for the information that should be included in such educational literature.

Chronic pain continues to be an under-diagnosed and under-treated problem, especially in the elderly. Elderly patients residing in long-term care facilities are at particular risk for developing complications from poorly managed chronic pain. By utilizing a multidisciplinary approach to managing pain and practicing according to nationally recognized treatment guidelines, the long-term care facility may become the best-equipped setting for the management of chronic pain.

Endnotes


