Evidence-Based Assessment and Treatment of Persistent Pain in the Community-Dwelling Elderly Receiving Home Health Services: A Pathway

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Persistent pain is a problem for a significant portion of the community-dwelling elderly. Many elderly are reluctant to admit to pain because of fears related to areas such as loss of independence and possible addiction. Cognitively impaired elders may have difficulty expressing persistent pain and understanding pain assessment questions. Because of these and other concerns, the home health nurse faces many challenges when assessing persistent pain in the community-dwelling elderly. A persistent pain pathway was developed to assist home health nurses at Senior Care in the assessment and treatment of persistent pain. Evaluation of its use after 3 months showed an agency-wide increase in client assessment and treatment of pain.

Persistent pain is a problem for the elderly living in the community. It not only interferes with function and contributes to decline but also decreases quality of life for the affected individual. In Missouri, the site of this project, approximately one in three individuals suffer with pain from arthritis and other joint disorders (Missouri Arthritis Rehabilitation Research & Training Center, 2002). Studies have shown that 25% to 86% of community-dwelling elderly individuals suffer from persistent pain and that osteoarthritis alone may be the source of persistent pain in as much as 80% of the population older than age 65 (Herr, 2002a). The home health nurse faces many challenges in assessing persistent pain in the elderly. Many elders do not disclose pain to caregivers because of perceived potential consequences such as loss of independence, fears of worsening health status, and possible addiction to pain medications (McCaffery & Pasero, 1999). The population of elderly is culturally diverse, and there is a growing segment of the population showing cognitive decline. All of these issues need consideration when assessing and treating pain in the elderly.

The purpose of this project was to develop a pain pathway to assist home health nurses in the assessment and treatment of persistent pain in the community-dwelling elderly. This pathway was intended to offer

**Key Words:** professional practice; evidence based; chronic pain; persistent pain; aged/elderly; critical pathways; home health care

Authors’ Note: Ms. Minner would like to dedicate this article to her brother, Mike Hage (1954-2000), MS, PT. Mike strove to alleviate pain and improve the quality of life for so many people through, practice, teaching, and example. Published with permission of Senior Care. Copies may be obtained by contacting De Minner at minnerd@health.missouri.edu or Karen Marek at kmarek@uwm.edu

This pathway is being revised in light of new information on NSAIDs.

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direction for assessment of persistent pain based on acceptable and current evidence-based nursing standards, both for those who are cognitively alert and those who are cognitively impaired. It also offers evidence-based recommendations for the pharmacologic and nonpharmacologic treatment of persistent pain in the elderly.

**Review of the Literature**

The prevalence of pain in the elderly has been shown to be twice that of younger individuals (Fulmer, Mion, & Bottrell, 1996), and the literature suggests that older adults who are cognitively impaired receive significantly less medication for the treatment of pain than their younger, alert counterparts (Herr, 2002b). There is also evidence that they receive significantly less pain medication than cognitively alert elders (Dennis, Safford, & Eland, 2001). In the 1999 National Pain Survey, researchers found that many aspects of life were affected by persistent pain. Besides work, the most commonly affected areas were activities of daily living (ADLs) such as walking, using steps, physical exercise, sports activities, and house cleaning (Curtiss & Schneider, 1999).

Fulmer et al. (1996) constructed a three-part pain management protocol for use in an acute care setting based on a review of the literature for both the cognitively impaired and the cognitively alert elderly. The three steps include assessment parameters, care strategies, and evaluation of expected outcomes. These steps were preceded by the goal that all elderly patients would be pain free or at a level of pain/discomfort that was acceptable to the patient (Fulmer et al., 1996). The authors suggest that nurses in a hospital setting must not forget to assess elderly patients for both acute pain and pre-existing persistent pain. Persistent pain assessment may become lost in the urgency of assessment and treatments related to the reason for admission. The reality is that ongoing, untreated painful conditions in the home health client as well as the hospital patient can hinder recovery and add to the list of comorbidities. For example, poorly controlled pain in an elderly individual with arthritis recovering from a knee replacement may delay or prevent full recovery.

Individuals with dementia have not been routinely included in studies dealing with persistent pain (Kovach, Weissman, Griffie, Matson, & Muchka, 1999). Kovach et al. (1999) looked at the use of the Discomfort-Dementia Alzheimer’s Type (DS-DAT) tool for assessing discomfort/pain in individuals with dementia in a 104-bed nursing home. The study was designed to (a) more accurately assess discomfort in individuals with dementia who had lost the ability to verbally make needs known, (b) better treat physical pain and discomfort, and (c) decrease inappropriate use of psychotropic medications. The DS-DAT is an observational tool that is based on nine behavioral indicators of the presence or absence of discomfort. There are two positive and seven negative indicators. These include noisy breathing, negative vocalizations, sad facial expression, frown, relaxed body language, tense body language, and fidgeting (Kovach et al., 1999).

The study was successful in identifying residents with discomfort and treating them through the use of nonpharmacological interventions and regularly scheduled analgesics (Kovach et al., 1999). However, during the study, there was no decrease in the use of psychotropics prescribed on an as-needed basis. Although this study showed mixed results, it supported the intriguing premise of using a first-line pharmacological intervention such as acetaminophen or ibuprofen as an assessment step as well as an intervention. If behaviors decrease or stop after administration, the behaviors may have been attributed to pain or discomfort. If the nurse feels further pain assessment is necessary, she or he could contact the physician or nurse practitioner for a different/stronger analgesic.

In an attempt to improve pain management in long-term care, the Medical College of Wisconsin Palliative Care Program began a project in 1996 in 87 Wisconsin nursing homes (Weissman, Griffie, Muchka, & Matson, 2001). It consisted of bringing together teams of clinicians, nurses, and physicians for a 1-day seminar on pain management and giving them suggestions to make changes in their own practice. A list of 14 target indicators of good pain management were developed and used to structure and evaluate the program. At the beginning of the project, only 12 facilities had more than half of the 14 indicators in place. By the completion, 64 of the 87 nursing homes had more than half in place. These indicators included assessment tools for cognitively alert and impaired residents, facility pain scales, an interdisciplinary pain team, education programs for residents and families, education for staff of all levels, and putting a working pain quality improvement process in place. The barriers that interfered with the project were identified as staff turnover, lack of time to devote to the process, and lack of a facility champion (Weissman et al., 2001). The champion was
seen as a key individual who recognized the problem of poor pain management and made a personal commitment to seek change through cheerleading and advocacy (Weissman et al., 2001).

Persistent, unrelieved pain can also be very expensive to the consumer and health care providers. Year-long studies from both the City of Hope National Medical Center and the MD Anderson Cancer Center revealed that the cost of admissions for unrelieved pain ran well into the millions of dollars for each institution (Curtiss & Schneider, 1999). In an attempt to address the problem, the City of Hope started a quality assurance program in pain management that instructed providers on the proper use of opioids, management of side effects, and assessment of high-risk patients. Nursing strategies were also implemented to improve pain management and accountability. As a result, the City of Hope reportedly saved $1 million during the following 12 months (Curtiss & Schneider, 1999).

SETTING

Senior Care is a home care agency that specializes in care of frail older adults. Operated by the University of Missouri Sinclair School of Nursing, Senior Care is a licensed Medicare-certified home health provider as well as a provider of community-based waiver services such as personal care and homemaking services. At the time of this project, Senior Care was testing an intervention called “Aging in Place” that centered around nurse care coordination of home care services to promote client independence and postpone or prevent nursing home placement. Each Senior Care client was assigned a nurse who would coordinate their care and check in with them at least every month or more frequently depending on their health care needs. Clients of Senior Care range in age from 40 to 104 with the average age at 85. The majority of clients have multiple chronic illnesses such as congestive heart failure, diabetes, arthritis, and atherosclerotic disease. About 30% demonstrate symptoms of cognitive decline and require assistance managing their health care, especially in the area of medication management. Persistent pain is a common problem experienced by this group.

Process

Appropriate pain management was an area of concern for the Senior Care nurses. The nurses felt that a persistent pain assessment and management pathway would greatly aid in the identification of those clients who are suffering and improve efficacy of treatment. Many of the clients are reluctant or not able to let the nurses know about ongoing pain. Some try to manage their own pain and do not readily disclose their discomfort or their actions to the nurse. The home health nurse often feels caught in the middle by trying to manage the client’s pain and promote healing and independence while also trying to ensure safety and efficacy of pain relief.

In home care, the Outcome and Assessment Information Set (OASIS) is a federally mandated assessment that is completed on all individuals receiving Medicare home health services (Shaughnessy, Schlenker, & Hittle, 1994). OASIS assessments are conducted on admission, at least every 60 days, at transfer to a hospital or other facility, after a significant change in condition, and at discharge. Data from the OASIS assessment are used to determine home health payment and create quality indicators that are used for benchmarking quality outcomes among home health care agencies. Two questions from the OASIS assessment screen are important for determining the presence of pain. The first item (MO420) addresses the presence of pain. If the score is 1 or higher, the client is positive for symptoms of pain. The second OASIS item (MO430) addresses the presence or absence of intractable pain. The clinical information system CareFacts™, Senior Care’s clinical information system, has a prompt that appears asking the user if pain should be included in the client’s care plan if the client is positive for pain during the OASIS assessment. Even with this prompt, nurses were not appropriately identifying pain as a problem for many clients.

PURPOSE

Persistent pain can hasten the decline in ability and loss of independence. As previously stated, the purpose of this project was to develop a useful pathway for care of the client with pain. With education about the pain source and its assessment and treatment in chronic disease management, some of the elderly clients may be able to take the initiative for self-management. Studies have shown that patient education programs alone can be an effective means of improving pain management in elderly individuals (American Geriatric Society, 2002). It is reasonable to believe that many clients will never be completely free of pain (American Geriatric
Society, 1998); therefore, goals for the client may be a
decrease that allows them to resume meaningful activ-
ity. Achievement of these goals can be looked upon as
some measure of success.

The use of a structured pathway for both assessment
and treatment of pain in the elderly client is a time sav-
ing and more focused approach to pain management. In
addition, understanding techniques for efficient assess-
ment and having an idea of the direction that pain man-
agement should take can help nurses be better patient
advocates. A standardized language and approach can
also help clients more accurately express their pain,
but care must be taken to be flexible enough to allow
for other types of personal expression. This is espe-
cially true for those clients with symptoms of dementia
(Miller, Linton, & Mezey, 2000).

The use of evidence-based practice in the formula-
tion of a persistent pain pathway is both an ethically
and legally sound way to initiate good practice. Basing
a protocol or pathway for the treatment of clients on
anecdotal evidence, opinion, or hearsay gives no basis
for sound clinical judgment. It also leaves the health
care provider and the represented agency without de-
fendable practice. Although no treatment is without the
potential for harm, those that are supported by the liter-
ature lend themselves to better overall management.
Without trial and support, situations can arise from
unfounded treatments that have little direction for safe
resolution. Whenever a health problem is recognized,
nurses and other health care providers are bound by the
ethical principals of their professions to improve condi-
tions for the clients they care for.

DEVELOPMENT

One consideration in the development of this path-
way was to avoid increasing the paperwork burden of
the nurses. Because of this, the assessment and man-
agement pathway included pain identification items
already present in OASIS. The pathway was intended
to be used as a guide to help nurses do the following:

1. Identify clients, both new and existing, who may be
   experiencing persistent pain (American Geriatric
2. Work to establish control of the cause of pain when-
ever possible (American Geriatric Society, 2002).
3. Use appropriate multidimensional assessment tech-
niques to assess both cognitively alert and
cognitively impaired clients. The client’s under-
standing and beliefs as well as what the pain means
to him or her are crucial to the success of treatment
(McCaffery & Passero, 1999). General assessment
areas covered should include
   — diagnoses,
   — OASIS items,
   — observation of activities of daily living,
   — behaviors that may indicate pain,
   — research-based pain rating scales,
   — medication history, and
   — client verbalizations.
4. Incorporate the interdisciplinary team including the
   client and the physician to establish and maintain
   reasonable goals to improve function, independence,
   and quality of life (McCaffery & Passero, 1999).
   This may be done through use of a combination of
   appropriate medications and nonpharmacological
   methods such as education, therapy, and exercise
   (American Medical Directors Association, 1999).
   All treatment should be tailored to individual needs
5. Promote continuity of communication between
   interdisciplinary staff, the physician, and the client
   (American Medical Directors Association, 1999).
6. Make pain assessment, management, and evaluation
   a focus of each visit by licensed nurses (American
   Geriatric Society, 1998).

A literature search was done for the most current
guidelines and innovative practice and research articles
on pain in the elderly. An extensive collection of perti-
nent pain guidelines and research and practice articles
was compiled and reviewed. Across guidelines, much
of the information was found to be consistent thereby
adding to the strength of evidence for inclusion. Prac-
tice articles were reviewed for innovation, the source of
information, practicality, and application. Research
articles were reviewed for findings, the strength of evi-
dence, practicality, and application. Derived informa-
tion was divided into the following categories:

- pain assessment of the cognitively alert elderly,
- pain assessment of the cognitively impaired elderly,
- pharmacological management,
- nonpharmacological management, and
- side effect management.

The pathway was constructed to include new and exist-
ing clients and incorporate an interdisciplinary team
approach to assessment. The World Health Organiza-
tion Analgesic Ladder was used as the basis for pharmacological management with the pharmacologic sections of the pathway including nonopioids, opioids, and adjuvants.

The pathway was reviewed by members of the Senior Care professional advisory committee, which included a physician, physical therapist, occupational therapist, social worker, nurse care coordinator, and the director of clinical services. In addition, a clinical nurse specialist and local physician who were experts in pain management reviewed the proposed pathway.

IMPLEMENTATION

Once the pathway was finished and approved by the Senior Care professional advisory committee, all licensed nurses were in-serviced on its use. The in-service consisted of a background on pain in community-dwelling elderly individuals; assessment techniques of both cognitively alert and cognitively impaired individuals including appropriate pain rating tools, barriers to assessment, and nonpharmacological and pharmacological interventions; side effect management; and communication between disciplines. Home health aides were included in the education offered and encouraged to assist the nursing staff in the monitoring and communication of pain in individuals seen regularly by support staff.

At the time of implementation of the pain pathway, 17% of the Senior Care clients who had pain identified on the OASIS assessment had pain targeted as the focus of a care plan problem. Ninety days after pathway implementation and education, 40% of clients with pain identified on the OASIS assessment had a specific nursing care problem for pain management. In addition, the OASIS outcome measure entitled Improvement in Pain Interfering with Activity improved from 24% the quarter before pathway implementation to 74% after the pathway was used. This means that after pathway implementation, more clients had less pain at discharge. The pathway is now part of the orientation for newly employed nurses at Senior Care (see appendix). It has emphasized to new licensed employees that pain assessment and treatment are a focus of the organization and gives them the tools to continue the focus.

All new clients are assessed by the registered nurses for pain within the context of his or her cognition. Treatment options are discussed with the physician and other members of the interdisciplinary team including the client and/or caregiver.

SUMMARY

Studies have shown that persistent pain in the community-dwelling elderly can affect quality of life and decrease function. Elderly individuals within the community fearing loss of independence may not disclose their pain to home health nurses. These individuals might also have the belief that chronic pain is a normal part of the aging process (McCaffery & Pasero, 1999). Untreated and undertreated pain can result in a downward spiral that increases confinement and debilitation of the individual. Chronic pain affects every aspect of life. A persistent pain assessment and treatment pathway may assist home health nurses in the consistent identification and treatment of persistent pain in this population. By using a standardized pathway to identify, treat, and promote safe management of pain, the independence and self-determination of our elderly residing within the community may be preserved and a more acceptable quality of life ensured.

APPENDIX

PERSISTENT PAIN PATHWAY ©

The purpose of this pathway is to aid in the consistent identification and effective treatment of persistent pain for clients receiving services from Senior Care (SC). It includes persistent pain assessment of new and existing elderly clients. Basic treatment options are included.

ASSESSMENT OF PERSISTENT PAIN

Assessment of New Admissions for Persistent Pain

Although most new admissions will enter the SC system with problems that will require the treatment of acute pain, many have been dealing with persistent pain.

1. Check for diagnoses that indicate persistent pain
   A. Examples: osteoarthritis, degenerative joint disease, cancer, previous surgeries or fractures, diabetes mellitus, post-herpetic neuralgias, post-cerebral vascular accident, etc.

2. Client or caregiver verbalizations of pain

3. Outcome and Assessment Information Set (OASIS) items that indicate pain
   A. Pain items: MO420 to MO430
   B. Activity of daily living (ADL) items: MO640, MO710

4. Physical assessment indications of persistent pain

5. Medication history: over the counter (OTC), prescription, herbal
Assessment of Existing Clients for Persistent Pain

Many clients in the SC system are long term. During the course of their association, changes may take place that may indicate new or worsening pain for the client. The elderly client should be assessed for new or worsening pain and treatment efficacy with each visit.

1. Existing or new diagnoses that may indicate persistent pain
2. Client or caregiver verbalization of new or worsening pain
3. Change in OASIS items that indicate pain
   A. ADL items: MO640 to MO710
   B. Pain items: MO420, MO430
4. Indications of change in routine or behaviors
5. Physical assessment indications of persistent pain
6. Observation
7. New or increase in use of OTC, prescription, herbal medications

General Assessment Guidelines for Persistent Pain in the Elderly

1. Assess location, type, quality, intensity, duration
2. Taking medications to relieve
   A. OTC
   B. Prescription
   C. Herbal remedies
   D. How much?
3. What makes it better/worse?
4. What is the meaning of pain to the client?
5. Client’s pain level on his or her very best day/very worst day/daily
6. Client’s understanding (barriers?), expectations, desires of pain relief
7. Pain rating scales—use scale appropriate to client’s cognition and comfort level
   A. Verbal-numerical 1-10, 1-5
   B. Vertical
   C. Nominal/descriptor/observational
8. Effects of persistent pain on
   A. Sleep
   B. Appetite
   C. Energy
   D. Activity
   E. Relationships
   F. Mood
9. Elderly clients may only associate the word pain with excruciating events
   A. Ask appropriate questions, for example
      i. Do your joints ache?
      ii. Do you feel stiff and sore in the morning?
      iii. What does that achiness keep you from doing?
   iv. Other words: tightness, heaviness, burning, discomfort, tingling, stinging, etc.
10. Observation of ADLs for change in comfort or ability, for example
    A. Ask client to put on socks or shirt
    B. Ask client to transfer on and off toilet or in and out of chair
    C. Observe ambulation for clues such as holding on to furniture
11. Evaluation of efficacy of all treatments for persistent pain, side effects encountered, and client response is part of ongoing assessment

Assessment of Persistent Pain in the Cognitively Impaired Elderly Client

1. Speak at eye level, face to face and use the client’s preferred name
2. Ask questions appropriate for the resident’s level of cognition
   A. For example, “I see you have arthritis. Do your hands hurt/are your knees sore?”
   B. May need to go joint by joint, area by area
3. Use physical cuing as you ask questions
   A. Gently touch knees, hands, etc. as you ask about them
4. Speak clearly and give client plenty of time to answer
5. Assess “in the moment”
   A. Client may or may not be able to tell you about past pain
6. Behaviors that may indicate pain
   A. Guarding, grunting, grimacing, fear, anxiety, pacing, wandering, postural changes, fidgeting, sadness, hallucinations, tense body language, tearfulness, reluctance, withdrawal, resistance, noisy breathing, gait changes, aggression
   B. Behaviors of long standing
      i. History of unrecognized pain?
7. Spouse/significant other/caregiver
   A. Ask about changes in routine or behavior
   B. Ask for help with interpretation of words or behavior
   C. Ask about increased or new vocalizations, aggressions, resistance to care

MANAGEMENT OF PERSISTENT PAIN IN THE ELDERLY CLIENT

Interdisciplinary Team Approach

This approach to management of persistent pain may benefit the client through the combination of different perspectives and approaches to care by creating a more compre-
hensive plan of care. Ongoing communication with all designated members is crucial.

1. Potential members include, but are not limited to
   A. Physician/advanced practice nurse—medical management
   B. Nurses—case management/implementation
   C. Occupational therapy (OT)/physical therapy (PT)/speech therapy (ST)—therapy consultation/intervention
   D. Social worker—resource referral/counseling
   E. Registered dietician—nutritional consultation/intervention
   F. Chaplain—religious needs/spirituality
   G. Pharmacist—medication/interaction/side effect consultation
   H. Home health aides—observation/communication of needs
   I. Client/family—contextual information/needs/wants
   J. Other—interventions as needed

Complementary Therapies

Although not all complementary therapies are evidenced in research, there is reason to believe that for certain people they can enhance the therapeutic effects of medications by allowing smaller doses to be given thus preventing or reducing side effects. Those that are starred are supported in the literature.

1. Potential complementary therapies
   A. Education*
   B. Cognitive/behavioral therapy*
   C. Exercise*
   D. PT/OT*
   E. Positioning
   F. Cutaneous stimulation (heat, cold, massage, acupuncture, vibration)
   G. Neurostimulation (transcutaneous electrical nerve stimulator, acupuncture)
   H. Chiropractic
   I. Psychological counseling
   J. Support groups
   K. Aromatherapy
   L. Music
   M. Relaxation

Pharmacological Management of Persistent Pain

1. World Health Organization Analgesic Ladder
   A. Mild pain: nonopioid +/- adjuvant
   B. Mild to moderate pain: weak opioid + nonopioid +/- adjuvant
   C. Moderate to severe pain: strong opioid +/- nonopioid +/- adjuvant

2. Nonopioids
   A. Acetaminophen (Tylenol)
   i. Maximum dose for elderly and those with liver damage of 3,000 mg to 4,000 mg daily
   ii. Has ceiling efficacy
   iii. For pain control with no inflammatory mediation—if ineffective at 650 mg to 1,000 mg three to four times a day, consider initiating low-dose opioid and titrating up to effective dose

B. Nonsteroidal anti-inflammatory (NSAIDs) to avoid in the elderly—increased frequency of serious side effects
   i. Indomethacin (Indocin)
   ii. Piroxicam (Feldene)
   iii. Tolmetin (Tolectin)
   iv. Meclofenate (Meclomen)

C. Commonly used NSAIDs (Cox 1 and 2 inhibitors)
   i. Ibuprofen (Advil, Motrin)—avoid high doses for prolonged periods of time
      a. High doses = 2,400 mg/day
   ii. Naproxen (Naprosyn, Aleve)—avoid high doses for prolonged periods of time
      a. High dose = 750 to 1,000 mg/day
   iii. When used chronically, should be used intermittently rather than around the clock
   iv. When used strictly for pain control, may consider switching to acetaminophen 650 mg to1,000 mg three to four times per day

D. Commonly used NSAIDs, Cox 2 inhibitors (fewer gastrointestinal side effects than Cox 1 inhibitors)
   i. May want to consider for some clients approaching maximum dose of acetaminophen without satisfactory relief or more than intermittent use of Cox 1 NSAIDs
   ii. Celecoxib (Celebrex)—used for osteoarthritis, rheumatoid arthritis
      a. Should not be given to clients allergic to sulfonamides, aspirin, other NSAIDs

E. Use all NSAIDs cautiously or avoid use in clients with
   i. Abnormal renal function
   ii. History of peptic ulcer disease
   iii. History of congestive heart failure

3. Topical analgesics
   A. Capsaicin cream
      i. Derived from red peppers
      ii. Depletes substance P and desensitizes nerve fibers associated with pain
      iii. Use routinely for optimal effectiveness
      iv. Begin with 0.025% and advance to increased concentration if necessary
Adjuvant Medications for Treatment of Persistent Pain

Adjuvant analgesics are defined as drugs that do not contain acetaminophen and that are not classified as NSAIDs or opioids. These drugs are not formally classified as analgesics. Adjuvants are often most effective when used for baseline pain management and supplemented by analgesics for breakthrough pain.

1. Tricyclic antidepressants
   A. Neuropathic pain, back pain, neuralgias, neuropathies
   B. Examples
      i. Secondary amines: nortryptaline (Pamelor), desipramine (Norpramin)
      ii. Tertiary amines: amitriptyline (Elavil)
   C. Anticholinergic effects: constipation, dry mouth, orthostatic hypotension, urinary retention, sedation; fewer of these effects with secondary amines
   D. Slow titration and weaning process recommended

2. Anticonvulsants
   A. Neuropathic pain, neuralgias, lancinating or burning pain
   B. Examples: gabapentin (Neurontin), valproic acid (Depakene), carbamazepine (Tegretol), clonazepam (Klonopin)
   C. Slow titration and slow weaning process recommended
   D. Obtain complete blood count and baseline liver function before starting carbamazepine

3. Antihistimines
   A. Not usually recommended for use with the elderly
   B. Examples: dyphenhydramine, hydroxyzine

Use of Opioids for the Treatment of Persistent Pain in the Elderly

Clinical experiences have shown that long-term use of opioids for treatment of persistent pain does not lead to tolerance or addictive behavior and unlike NSAIDs appears to present no risk of systemic damage. Opioids should be used cautiously, educating the client and caregiver to potential side effects and benefits.

1. Opioids
   A. Opioids to avoid in the elderly client
      i. Meperidine (Demerol)
      ii. Propoxyphine (Darvocet)
      iii. Nalbuphine (Nubain)
      iv. Pentazocine (Talwin)
      v. Butorphanol (Stadol)
   B. Common opioids prescribed alone and in combination
      i. Morphine (Morphine Sulfate [MS] Contin, MS Immediate Release [MSIR])
      ii. Transdermal fentanyl (Duragesic); not for opioid-naive clients
      iii. Hydromorphone (Dilaudid)
      iv. Codeine, also with acetaminophen or aspirin (Tylenol #3)
      v. Hydrocodone, also with acetaminophen or aspirin (Lortab, Vicodin)
      vi. Oxycodone, also with acetaminophen or aspirin (OxyContin, Percocet)
   C. Management of osteoarthritis and musculoskeletal pain
      i. Appropriate complimentary treatment
      ii. PT/OT
      iii. Topical analgesics
      iv. Acetaminophen
      v. NSAIDs
      vi. Tramadol—if client wishes to avoid opioids
      vii. Opioids
   D. Management of neuropathic pain
      i. If pain is disease related, establish control
      ii. PT/OT
      iii. Topical analgesics
      iv. Anticonvulsants/tricyclic antidepressants
      v. Acetaminophen
      vi. NSAIDs
      vii. Tramadol—if client wishes to avoid opioids
      viii. Opioids
   E. Considerations for use
      i. Start with lowest dose and titrate up slowly
      ii. Use oral route whenever possible
      iii. Opioid therapy should be considered complementary to other analgesic and rehab approaches
      iv. When changing from one opioid to another (includes tramadol, start with half recommended starting dose or half the equivalent analgesic dose and titrate up slowly
      v. For end of dose failure, if appropriate, may try same total 24-hour amount given in lower doses more frequently
vi. For breakthrough pain, use short-acting, fast-onset preparations
vii. Educate client and family about potential side effects
viii. Chose pain control options appropriate for client and family setting

Opioid Side Effects

Management of side effects can be crucial to the success or failure of treatment. Unmanaged side effects can add to the debility of the client and create significant comorbidities.

1. Constipation: tolerance is never developed; start on bowel regimen with start of opioid or tramadol; exception is clients with chronic diarrhea
2. Sedation: common with start, change of opioids, or with previous sleep deprivation from pain
   A. Assessment: check oxygen saturation, respiations, look for pinpoint pupils
   B. Asses for other causes
   C. If sleep deprivation, allow a few days to catch up
   D. If change or start of new opioid, allow 48 to 72 hours to adjust
   E. If sedation continues, may need to decrease dosage or change drugs
3. Dry mouth
   A. Encourage hydration
   B. Sugar-free hard candies or gum
   C. Sour foods such as pickles or sour candies
   D. Oral saliva sprays

Evaluation and Communication

1. Does evaluation of pain and efficacy of interventions take place with each visit?
2. Are all team members aware of the goals of pain management and care for the client?
3. Are pain management and evaluation and side effect management an automatic part of the plan of care?
4. Is the client/caretaker aware of the goals, interventions, limitations, advantages, potential side effects, and what to do if problems arise?
5. Do team members communicate findings, problems, solutions, and successes to other team members?
6. Is documentation clear, concise, and complete in all necessary areas?

REFERENCES


Karen Dorman Marek, PhD, MBA, RN, FAAN, is an associate professor at the University of Wisconsin—Milwaukee College of Nursing. At the time of this project, she was executive director of Senior Care Home Health in Columbia, Missouri. Her research interests are in the area of community-based long-term care and nursing interventions to promote independence in frail older adults.

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