As part of its Dignity on the Ward campaign, Help the Aged commissioned a series of pocket guides that began with *Working with Hospital Patients with Dementia or Confusion*. Other titles in the series include *Promoting Dignity in Hospital, Bereavement and Loss* and *Working with Older People from Ethnic Minority Communities* as well as this title, *Pain and Older People*.

We hope that this guide will help hospital staff to understand better the needs of vulnerable older patients and their families and perhaps to appreciate more fully the importance of taking a person-centred approach.

Fighting for disadvantaged older people in the UK and overseas, WE WILL:

**COMBAT POVERTY** where older people’s lives are blighted by lack of money, and cut the number of preventable deaths from hunger, cold and disease

**REDUCE ISOLATION** so that older people no longer feel confined to their own home, forgotten or cut off from society

**CHALLENGE NEGLECT** to ensure that older people do not suffer inadequate health and social care, or the threat of abuse

**DEFEAT AGEISM** to ensure that older people are not ignored or denied the dignity and equality that are theirs by right

**PREVENT FUTURE DEPRIVATION** by improving prospects for employment, health and well-being so that dependence in later life is reduced

Pain and Older People

A guide for hospital staff
Background to the project

This pocket guide has been developed for nursing staff in clinical areas as a resource to assist in managing pain in older adults. It has been developed to assist nurses in their decision making regarding treatment or referral to appropriate members of the multidisciplinary team. Our thanks go to the members of the project steering group for their contributions and insights into their roles.

Steering group

Dr Pat Schofield,
Senior Lecturer, University of Aberdeen (project leader)

Dr Paula Smith
Senior Lecturer & Health Psychologist, Sheffield Hallam University

Dr Denis Martin
Reader in Rehabilitation, University of Teesside

Barry Aveyard
Senior Lecturer, Sheffield Hallam University

Catherine Black
Senior Lecturer, DHSS Education and Training Centre, Isle of Man

Rachel Drago
Freelance pharmacology lecturer

Note This publication is not intended to be a guide to the clinical treatment of patients.

Contents

Introduction 2

What is pain? 2

Understanding pain in older people 4

Assessing pain in older people 5

Influences on pain 7

Managing pain 10

Older people’s views 15

References and websites 16
Introduction

This pocket guide is designed to highlight some of the key issues to be considered when dealing with older adults in pain. It has been developed to increase understanding of the assessment and management of pain in this group and to provide insight into the contributions that can be made by members of the multidisciplinary team. The information has been distilled from patient experience, nursing practice and academic research.

Specifically, the guide will help you to:

- understand the nature of pain in the older age group
- recognise pain in older adults and be aware of tools available to measure intensity
- consider the wide range of factors that can influence a person’s pain
- understand the contributions that can be made by members of the multidisciplinary team
- consider issues relating to rehabilitation and function
- be aware of the limits of pharmacological interventions
- understand the role of complementary therapies and when they may be appropriately used to support traditional approaches.

What is pain?

‘Pain is whatever the experiencing person says it is and occurs when he/she says it does.’ (McCaffery, 1968)

While this is a commonly quoted definition, there are groups who cannot say they have pain: for example, older people with learning disabilities, with speech loss or with cognitive impairment. A more appropriate definition may be the one proposed by the International Association for the Study of Pain:

‘An unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage.’ (IASP, 1979)

Types of pain

Pain can be associated with an injury, but it can also be present without any identifiable cause. Pain can be acute or chronic, and described using a range of terms:

- burning
- shooting
- stabbing
- throbbing
- hot
- cold
- achy
- nagging
- pins and needles.

Physiology

Nerve fibres that detect injury are located all around the body. These nociceptors, known as α-delta and c fibres, transmit into the nervous system via the spinal cord and ultimately arrive at various centres within the brain. At this stage almost all of the brain becomes involved and collectively interprets this initial noxious stimulus as pain.

In 1965, Melzack and Wall highlighted the potential influence of the pain gate which can mediate the pain impulses, thus altering the intensity and distress of pain experienced. Techniques such as TENS, acupuncture, relaxation and distraction can help ‘close the pain gate’. Individuals also have the ability to produce chemicals which can help to control the pain. These are known as endogenous opioids. Think of the marathon runner who ‘breaks the pain barrier’.

Chronic pain becomes persistent because of changes in the pain processing system, both at the nerve endings and in the spinal cord, where cells that were previously ‘asleep’ become activated and start sending pain signals to the brain. Known as ‘wind-up’, this is one of the reasons why chronic pain does not go away easily, even if the cause of the pain is discovered and treated.
Common causes of pain in older adults

Pain can be:
- musculoskeletal
  * osteoarthritis
  * spinal canal stenosis
  * fibromyalgia
- peripheral neuropathy
- post-herpetic neuralgia
- post-stroke
- cancer.

Assessing pain in older people

If pain is to be managed properly, it must first be thoroughly assessed. The best way to assess pain is to ask the person experiencing it to describe it. Questions to consider when assessing pain are:

- When did you start getting this sort of pain?
- What makes the pain get better? What makes it worse?
- What triggers the pain, for example, movement, cold?
- How does the pain make you feel?

Understanding pain in older people

For anyone, pain is an unpleasant and un-dignifying experience. However, there is evidence (Hall-Lord et al 1999) that pain in older people pain is not taken seriously. Significantly, assumptions are made by caring staff and older people themselves that pain is an inevitable part of the ageing process. This is clearly not the case.

Points to remember when working with older people:
- Older people may be so familiar with their pain they no longer recognise it
- Pain is experienced differently by different people
- Pain is described in different ways, and may not be referred to as pain but as hurt, discomfort etc.
- As pain can inhibit mobility it is important to manage pain well to prevent decreasing functionality
- Older people frequently suffer from several pains at once
- Older people may be on a mix of medications which are in turn leading to painful or uncomfortable side effects
- Older adults experience the same range of conditions arising from trauma, tissue and nerve damage as their younger counterparts
Influences on pain

Pain is a complex experience influenced by a wide range of factors.

Total pain concept

Dame Cicely Saunders, the founder of the hospice movement, was the first to identify the total pain concept. The concept presents pain as being an amalgam of factors beyond the physiological. Twycross (1997; and Twycross and Wilcock 2002) developed the concept to incorporate four domains, while Paz and Seymour (2004) highlight how pain is very individual and is not just a physical sensation.

The four domains of the total pain concept are:

- **physical** The total amount of physical pain experienced may be the result of the illness or disease or unwanted side effects resulting from treatments.

- **social** Family roles, financial effects, friendships and isolation all contribute to the impact of pain. For example, older people may have particular concerns such as caring for another person or a pet, or living alone, which can reduce their ability to deal effectively with their own pain.

- **psychological** The individual’s feelings, coping strategies and previous adjustments to pain influence the intensity of the pain experience.

- **spiritual** This concerns the meaning of and beliefs about illness, perception of the past and future, and issues relating to faith that concern an individual.

Key points

- **Everyone is an individual and their unique needs must be taken into consideration**

- **Communication works on many levels: be prepared to use a range of skills**

- **Be aware of the range of pain assessment tools available**

- **Select an appropriate assessment tool to meet the needs of the person**

- **No one tool is right for all older people**

The most effective way to assess pain intensity is to use a pain tool. A number of recognised pain measurement tools are available. The literature suggests that older adults with moderate, mild or no cognitive impairment are best suited to the verbal descriptor scale (none, mild, moderate, severe) or the numbered visual analogue scale. However, it is important not to assume a one-tool-suits-all approach.

Some older people are not able to describe their pain due to confusion, sensory impairment or communication difficulties. Such factors must not be allowed to become barriers to proper pain assessment. Instead, we need to look for behaviours that may indicate that pain is present. The most popular tools that help us identify these behaviours appear to be the Abbey or Doloplus scale, both of which can be downloaded from the internet. They score the behaviours to indicate levels of pain which can provide the equivalent of a pain score.
Krishnasamy (2001) believes that one of the nurse’s greatest challenges in pain management is to consider the individual’s experience of pain, and to understand the factors outside the purely physical that impinge on this. She identifies a number of questions that can be used to evaluate and assess the experience of pain from the individual’s perspective. These questions focus on the patient’s perspective of when they were first ill, how family and friends reacted, what makes any pain better, fears for the future, and how life plans may have been altered.

Assessing pain from a multidimensional standpoint results in information about how the patient perceives the pain and the impact this is having. This approach is also likely to help the patient overcome their reluctance to be open and honest about their experience. Such information can be particularly important when caring for older people as they are often reluctant to share such experiences if they feel their ‘trivial worries’ will hold up busy health professionals. Alternatively, they may believe that pain and its consequences are to be expected and that they should just ‘put up’ with it.

Often people have learned adaptive coping strategies to deal with a chronic pain, such as using a hot water bottle or cold compress, or moving the position of the painful limb to a more comfortable position. However, these simple but effective methods may not be available to them or effective for a new or acute pain.

Isolation may also affect the ability of the individual to deal with pain, as having a concerned person nearby can help to distract the individual and prevent them from concentrating on their pain. Being isolated can mean that the older person has less practical help in relieving the pain.

Assessment of psychosocial issues therefore needs to identify the factors which influence the experience and the method of coping with pain. Most older people believe it is ‘normal’ to experience pain as they get older and so are less likely to report their discomfort. There is also a strong possibility that multiple pathologies will affect the individual’s experience of pain.

**Key points**

- I didn’t like to worry the nurse with my arthritis pain
- Who is going to look after my cat if I’m ill?
- I usually find a hot water bottle helps the pain in my back
- Well, you’re bound to get some pain as you get older
- Consider the social support available to the person
- Think about any spiritual issues that might be important
Managing pain

Rehabilitation and function

Pain can affect an older person’s ability to move and to carry out daily functions. It is therefore helpful to carry out the following procedures when working with older people.

- Assess the person’s ability to carry out a specific activity: for example, tying shoelaces
- Suggest a graded exercise programme, to increase level of activity gradually
- Refer to physiotherapy and occupational therapy if specialist input or devices are required.

Pharmacological management

Apart from the obvious factors associated with pharmacology, including side effects, contraindications and dosing, a number of specific age-related factors should be taken into account.

- Older people have distinct changes in their physiology due entirely to age and not to pathological processes.
- All drugs can be poisonous regardless of the age of the individual.
- All pain should be treated using a multimodal approach regardless of age.
- Drugs tend to produce greater and more prolonged effects with increasing age. This is due in the most part to the changes in the physiological responsiveness of the older human body (Mangoni and Jackson 2003).
- Age-related changes that occur include:
  - change in proportion of muscle to fat, which alters the metabolic rate of a drug
  - Ventricular failure and hardening of arteries, which may influence the distribution of the drugs
  - Reduction in liver functions, which in turn reduces metabolism
  - Reduction in renal excretion of drugs, leading to accumulation of a drug within the body.
Non-pharmacological approaches

Once it has been established that the person has pain, the initial treatment is often pharmacological (drug treatment). However, other, non-pharmacological, treatments should also be considered. Such treatments are known by a variety of names including:

- complementary therapies
- alternative therapies
- complementary/alternative approaches to medicine (CAM).

It is recognised that some of these have an important role to play in the management of chronic pain in older people, and can be used successfully by all members of the MDT. Some of the therapies will require the person to be referred for specialist support; however, others can be carried out on the ward by the existing team. All of them require hospital staff to have some knowledge of the therapies and their uses, and a consistent team approach to these. Staff should also always ask the patient, and/or their relative or friend if appropriate, if they are interested in using complementary therapies.

These may include relaxation, music, pacing (helping the older person to carry out new activities in easy stages), goal-setting (enabling the older person to set targets for what they want to achieve), TENS machine (for localised nerve stimulation), heat and cold (to help manage local pain).

In good health these changes do not pose a major problem to the individual. However, in disease and ill health these changes do need to be included in the equation when considering treatment, route administration, doses and time interval:

- Older adults, like any other age group, will respond better to treatment if they are given the opportunity to make an informed choice. Therefore explanation is essential, and the individual should be given the opportunity to ask questions and to decide whether or not they wish to participate in the treatment plan.

- Drugs should be labelled clearly and the rationale and timings clearly explained. It goes without saying that bottles should be easy to reach and open, and labels easy to read. Guidance should be given on side effects and contraindications.

- The aim of the medication management should be discussed with the patient so that they know whether the aim is pain control or pain reduction.

- Finally, doses should be as low as possible while providing a therapeutic effect, and the whole regime must be closely monitored.

Consideration of all of these factors should encourage good communication and coherence in the delivery of help to the patient. There are far too many instances of treatment-induced disease through drugs and polypharmacy in the older adult. Accumulation and toxicity are problems that can be avoided through the recognition and attention to age-related physiological changes.

Care with routes of administration, dosages and time intervals may prevent some common problems, as will patient education and support.
Older people’s views

Consider some of the issues highlighted recently in a study where care-home residents were interviewed about pain:

‘I don’t like to complain – the staff are very busy. I have been in pain in my spine over 20 years now.’

‘They give me injections every six months, but they do not help, not even for a couple of days.’

‘I do not tell the staff, as they would send me back in hospital. I am not going back in there, so I do not let them know.’

‘Real pain – like childbirth. More like a toothache, you can live with it. This is what happens when you get to my age.’

‘I do not like to complain to the night staff – they are very busy – so I just lay there and hope that I can get back to sleep. I do not sleep much anyway. They are so busy, they have not got time to mess around with me. There are others much worse off.’

‘I am not a young man and would expect to be in pain at this age, so taking tablets is not the answer. You can live with pain, but not the way the drugs make you feel.’

All pain is influenced by many factors irrespective of the age of the individual: while we have guidance regarding the most appropriate management, individuals may have their own views on how they wish their pain to be managed. However, effective pain control is a realistic and achievable goal.
References and websites


International Association for the Study of Pain (1979) Subcommittee on taxonomy of pain teams: a list with definitions and notes on usage. Pain 6, 249–52.


 Websites

http://www.britishpainsociety.org/
http://www.efic.org/
http://www.iasppain.org//AM/Template.cfm?Section=Home
http://www.who.int/en/