

# PAIN MANAGEMENT DECISION-MAKING FRAMEWORK

for nurses and care staff caring for  
people with advanced dementia

**TRAIN THE TRAINER MANUAL**  
**for RACF EDUCATORS**

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## Introduction

The pain framework consists of the following components:

- guidelines;
- flowcharts;
- Pain Management Record Form;
- Weekly Outcomes Review Form;
- Comprehensive Assessment Form;
- supporting information.

Listed below are the knowledge and skills you should expect your nurses and care staff to have to enable them to provide effective care for residents with advanced dementia who experience pain, and suggestions for training if an individual is not competent to provide care.

Timely assessment and management of symptoms is a major component of a palliative approach to dementia care. All nurses and care staff have a responsibility to ensure they are able to assess and manage pain experienced by residents, within their scope of practice.

This manual is to be used in conjunction with the *'Pain decision-making framework for nurses and care staff caring for people with advanced dementia'*, 'Guidelines' and 'Supporting Information'.

It is recommended that training be offered regularly, so that all nurses and care staff are able to master the required knowledge and skills within three months of commencing employment in the facility.

### **Palliative Care Australia resources**

Palliative Care Australia have developed a number of resources to assist with training in a palliative approach to care. Use the resources (available from <http://www.pallcare.org.au>) to supplement this training package.

We recommend that as many staff as possible complete the two competency-based modules in a palliative approach to care:

- CHCPA01A: Deliver care services using a palliative approach;
- CHCPA02A: Plan for and provide care services using a palliative approach.

# Required knowledge and skills

## All nurses and care staff

- know what the pain threshold is, and how it can be lowered and raised;
- know what the common causes of acute and chronic pain are in older people;
- know that cultural beliefs about dementia, and cultural beliefs within residential aged care facilities, may act as barriers to the management of pain in people with advanced dementia, and should be challenged;
- know that there are negative consequences of untreated pain for the resident that impact on physiological function, psychological status, and quality of life;
- describe the differences between acute pain, chronic pain, incident pain, breakthrough pain and acute-on-chronic pain;
- know that a resident with advanced dementia will frequently be unable to verbally communicate their pain, and close observation of their behaviour is required;
- know that all members of the care team, including the family and other regular visitors, have a role to play in identifying the possibility of pain in a person with dementia;
- be able to state why self-report of pain is best;
- be able to complete both self-report and behavioural observation pain tools, document the findings, know when to use these tools, and know the limitations to the use of behavioural observation scales;
- know when to use non-medication strategies for pain;
- know to whom and when to refer persistent pain for further assessment, in keeping with the goals of care of the resident;
- know the general principles of analgesic use, especially the importance of using medication 'around the clock', not 'as necessary' for chronic pain relief for people with advanced dementia;
- know that there are potential side effects associated with the use of all types of medication used to treat pain, and that residents need to be monitored for potential side effects;
- know the common myths and misconceptions associated with opioid use so they can challenge and provide information to dispel the myths;
- use the 'pain framework' to identify the action required when a resident with advanced dementia shows behavioural changes.

## **Enrolled nurses and registered nurses**

\* NB a care staff member (eg Assistant in Nursing) may have sufficient knowledge and skills to undertake some of the tasks associated with pain assessment and management within this section.

All of the above knowledge and skills, and:

- advocate on behalf of the resident whose pain is not well controlled;
- know that pain is multidimensional, affects many older people, including those with dementia, and has serious consequences for a resident if not adequately treated;
- describe nociceptive and neuropathic pain, and know the differences in their quality and presentation;
- be able to complete a pain history and assessment, and use all available information to plan the goals of pain management for the resident, in consultation with the resident (if appropriate), the family members, the general practitioner, and other facility staff;
- undertake a simple physical assessment of a resident with advanced dementia to assess the location of pain;
- know how the WHO analgesic ladder is used;
- know how to use 'breakthrough medication' if required, and when to contact the general practitioner for advice;
- know that co-analgesic medications can be used in combination with analgesics to relieve pain;
- know the routes of opioid administration and the rationale for their use;
- know why immediate release morphine is the analgesic of choice when starting strong opioids;
- be able to calculate the dose of morphine when changing from immediate release morphine to slow release morphine; when a breakthrough dose is required when the resident is receiving immediate release morphine; and when changing a resident from oral to subcutaneous morphine.
- know the major risks associated with the use of paracetamol and NSAID's;
- describe the basic approaches to the management of potential side effects of opioids such as sedation, constipation and nausea and vomiting;
- be able to collaborate with the general practitioner, physiotherapist, specialist geriatrician and/or palliative care specialist to address issues relating to pain and its management;
- understand the role of the nurse in family conferences and be able to participate in a multidisciplinary family conference for a resident receiving a palliative approach to care, including determining the goals of care for the resident.

# SECTION ONE: KNOWLEDGE and SKILLS

## All Nurses and Care Staff

The basic knowledge and skills required to enable all nurses and care staff to understand the assessment and management of pain in residents with advanced dementia are listed below.

Organise inservice education as required. Ensure all registered and enrolled nurses are aware of the correct reporting and recording requirements for pain monitoring within the facility, so they can adequately supervise the work of the care staff.

<b>Can every nurse and care staff member:</b>	<b>Yes</b>	<b>No</b>	<b>If no, then:</b>
Describe what the pain threshold is, and name 3 factors that can lower the pain threshold, and 3 that can raise the pain threshold?			Refer to page 7 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that the pain threshold is the point at which increasing stimuli are felt as painful, and this point can be lowered by discomfort, anxiety, fear, boredom, depression, feeling abandoned; and that the point can be raised by providing relief of other symptoms, companionship, diversional activities, medications.
Name 3 of the common causes of chronic pain and acute pain in older people?			Refer to page 7 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that chronic pain is commonly caused by degenerative joint disease, spine disease, and leg and foot disorders; while acute pain is from cancer, fractures and infections.
<ul style="list-style-type: none"> <li>Describe some cultural beliefs that may act as barriers to the management of pain in people with advanced dementia;</li> <li>Describe some of the negative consequences to the resident of untreated pain.</li> </ul>			Refer to pages 7-8 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that beliefs such as that nothing can be done about pain among people with dementia, and that people with dementia don't experience pain, stop facility staff from effectively managing pain and should be challenged. Residents with untreated pain are more socially isolated, have gait disturbances, poorer

<b>Can every nurse and care staff member:</b>	<b>Yes</b>	<b>No</b>	<b>If no, then:</b>
			nutrition, more falls, depression and decreased quality of life.
Describe the differences between acute pain, chronic pain, incident pain, breakthrough pain and acute-on-chronic pain;			Refer to pages 10-11 of the 'Supporting Resources'. Conduct a short inservice education session if required. Stress that there are a number of different types of pain, and that a resident can be experiencing more than one type at a time, in a number of different parts of the body.
<ul style="list-style-type: none"> <li>• Name 5 behavioural indicators of pain;</li> <li>• Describe why it is important for all members of the care team to report pain, including the family and other regular visitors.</li> </ul>			Refer to pages 12-13 of the 'Supporting Resources'. Conduct a short inservice education session if required. Stress that there are numerous facial expressions, vocalisations, body movements, changes in interpersonal interactions and mental status changes that could be the result of pain. Care staff and other people who know the resident well are in the best position to report behavioural changes that may be due to pain, and should be encouraged to do so, bearing in mind that family members may overestimate the severity of pain, while doctors and nurses underestimate it.
State why self-report of pain is the 'gold standard' (ie best).			Refer to pages 12-13 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that the severity of pain cannot be judged by any method other than having the person feeling the pain, say how bad it is. This means that only by self-report can anyone know the severity of pain, so behavioural observation cannot give than information.
<ul style="list-style-type: none"> <li>• Demonstrate that they can accurately complete a self-report pain tool, and know where to document the result;</li> <li>• Demonstrate they can accurately complete a behavioural observation pain tool and know where to document the result;</li> <li>• Describe the limitations to the use of behavioural observation scales;</li> <li>• State when pain assessment tools should be</li> </ul>			Refer to pages 13-16, 32, & 44-54 of the 'Supporting Information', and pages 3-7 & 21-24 of the 'Guidelines'. Conduct a short inservice education session if required. Stress the importance of trialling a self-report tool first, before changing to a behavioural observation tool, because self-report is best. Ask the staff member to choose a cognitively intact resident and complete a behavioural observation tool. When the behavioural observation tool is completed and documented, ask the staff member to approach the resident

<b>Can every nurse and care staff member:</b>	<b>Yes</b>	<b>No</b>	<b>If no, then:</b>
used.			and complete a self-report tool, document the result and compare the results from the 2 tools. Emphasise that residents having their pain assessed by behavioural observation tools are more likely to have less pain identified, and receive less analgesics than a resident able to report his/her own pain. Discuss that tools are a lot less effective than physical assessment, and are best used before and after pain interventions to evaluate the effectiveness of the intervention. Evaluation needs to continue until the pain has been settled for 48 hours, after which monitoring by discussing daily and reviewing weekly can occur.
State when they would use non-medication strategies for pain?			Refer to pages 18-19 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that mild, transient pain, and pain of unknown cause, can be treated initially with non-medication interventions. If after evaluation they are found to be ineffective then medication needs to be given.
Describe how and when they would refer persistent pain for further assessment, in keeping with the goals of care of the resident.			Conduct a short inservice education session if required. Stress that persistent pain needs to be reported to the nurse in charge and interventions given until the pain is settled, and that pain that remains unsettled after 24 hours should be discussed with the general practitioner.
Describe why using 'around the clock' pain relief is important for people with advanced dementia with pain.			Conduct a short inservice education session if required. Stress that a person with advanced dementia will NEVER be able to ask for additional pain medication, so giving it regularly throughout the day and night prevents peaks and troughs that might mean that pain management is effective some of the time and not all of the time.
Describe the potential side effects they might see if a resident is started on a weak opioid eg a <i>Norspan</i> patch.			Refer to pages 22-25 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that <i>Norspan</i> patches might cause drowsiness, constipation, additional confusion, itchy skin and a slowing of breathing

Can every nurse and care staff member:	Yes	No	If no, then:
			among other potential side effects that need monitoring for when the resident starts the medication or has his/her dose increased.
Describe 3 common myths and misconceptions associated with opioid use, and state the correct information that dispels the myths.			Refer to page 43 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that strong opioids like morphine will not hasten death, cause addiction, and can be used safely well before death is imminent to keep a person comfortable.
Use the 'pain framework' to identify the action required when a resident with advanced dementia shows behavioural changes that may be due to pain.			Refer the staff member to Figure 2, page 4 of the 'Guidelines'. Conduct a short inservice education session if required. The principles of care are to assess to find the cause of the pain if possible, and manage the pain with both non-medication and medication interventions. Evaluation of all interventions should be undertaken, and continued until the pain has settled. Referral to the general practitioner should occur when advice on treatment and palliation of symptoms is required.

## SECTION TWO: KNOWLEDGE and SKILLS

### Registered and Enrolled Nurses

All registered and enrolled nurses are expected to have knowledge and skills as outlined in Section One. In addition, they should demonstrate more comprehensive knowledge and skills relating to pain assessment and management as outlined in this section. Organise inservice education as required. NB a care staff member (eg Assistant in Nursing) may have sufficient knowledge and skills to undertake some of the tasks associated with pain assessment and management within this section.

- ✓ To assess knowledge, ask every registered nurse and enrolled nurse to complete all 32 questions of the Quiz (page 15 of this document) to provide a baseline measure before undertaking education relating to pain;
- ✓ correct the quiz questions, and provide a short inservice education session relating to any topic that a number of nurses found difficult, or responded to incorrectly;
- ✓ for an individual nurse having difficulty with a specific topic area, discuss the problem with him/her and refer to the relevant sections of the 'Guidelines' and 'Supporting Information' for review. Advise the staff member that he/she will be asked to repeat the Quiz in one month;
- ✓ repeat the Quiz questions with the individual nurse. If the nurse still cannot correctly respond to a question(s), review the problem topic again with him/her. Discuss the issue with facility management if there is a likelihood that the knowledge deficit will impact negatively on the care of the residents, so the nurse's performance can be monitored appropriately.

Can every registered nurse (RN) and enrolled nurse (EN):	Yes	No	If no, then:
<ul style="list-style-type: none"> <li>• Describe the role of the nurse in advocating on behalf of a resident whose pain is not well controlled;</li> <li>• Answer question 30 of the Quiz correctly.</li> </ul>			Refer to pages 5 & 20 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that the nurse's role as an advocate includes collaborating with members of the multidisciplinary team, preparing for consultations, reviewing facility policies and procedures, and bringing problems to the attention of facility management.
<ul style="list-style-type: none"> <li>• Understand that pain is multidimensional, affects many older people, including those</li> </ul>			Refer to pages 6-7 & 12 of the 'Supporting Information'. Conduct a short inservice education session if required.

<b>Can every registered nurse (RN) and enrolled nurse (EN):</b>	<b>Yes</b>	<b>No</b>	<b>If no, then:</b>
<ul style="list-style-type: none"> <li>with dementia, and has serious consequences for a resident if not adequately treated;</li> <li>• Answer questions 13, 14, 17, 22 &amp; 23 of the Quiz correctly.</li> </ul>			
<ul style="list-style-type: none"> <li>• describe nociceptive and neuropathic pain, and know the differences in their quality and presentation;</li> <li>• know the signs of acute and chronic pain;</li> <li>• answer questions 2, 3, 15, 27 &amp; 29 on the Quiz correctly.</li> </ul>			Refer to pages 9-10 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that pain is classified in different ways; and that nociceptive and neuropathic pain are the most commonly experienced by older people.
<ul style="list-style-type: none"> <li>• Undertake and record a history of pain and treatments used for pain for a new admission, or a review of a resident;</li> <li>• Complete a brief physical assessment;</li> <li>• Describe where to record the history and examination findings;</li> <li>• Develop a pain care plan based on the resident's history, behaviours, and preferences?</li> </ul>			Refer the nurse to pages 8-10, & 18-20 of the 'Guidelines'. Use the facility pain management record form and care plan, or the Comprehensive assessment Form provided in the 'Guidelines'. Conduct a short inservice education session if necessary. Stress the importance of regularly updating the care plan to reflect the goals of care relating to pain management.
<ul style="list-style-type: none"> <li>• Provide direction for care staff in the use of pain assessment tools, and when to use them;</li> <li>• Answer questions 1, 24, 26 &amp; 28 of the Quiz correctly?</li> </ul>			Refer to pages 13-16, 32, & 44-54 of the 'Supporting Information', and pages 3-7 & 21-24 of the 'Guidelines'. Conduct a short inservice education session if required.
<ul style="list-style-type: none"> <li>• Outline the steps on the WHO analgesic ladder, and how the ladder is used;</li> <li>• know how to use 'breakthrough medication' if required, and when to contact the general practitioner for advice;</li> <li>• know that co-analgesic medications can be used in combination with analgesics to relieve</li> </ul>			Refer to pages 19- 21 of the 'Supporting Information'. Conduct a short inservice education session if required. Stress that simple analgesics should be used first, before progressing up the ladder and adding opioids and co-analgesics if necessary. Stress that breakthrough doses of medication should be given as ordered if required, as they indicate to the medical practitioner that the dose and/or type of analgesic needs to be

<b>Can every registered nurse (RN) and enrolled nurse (EN):</b>	<b>Yes</b>	<b>No</b>	<b>If no, then:</b>
pain; <ul style="list-style-type: none"> <li>• answer questions 4, 5 &amp; 18 of the Quiz correctly.</li> </ul>			changed.
<ul style="list-style-type: none"> <li>• know the routes of opioid administration and the rationale for their use;</li> <li>• know why immediate release morphine is the analgesic of choice when starting strong opioids;</li> <li>• be able to calculate the dose of morphine when changing from immediate release morphine to slow release morphine; when a breakthrough dose is required when the resident is receiving immediate release morphine; and when changing a resident from oral to subcutaneous morphine;</li> <li>• answer questions 6,10,12,15, 16,19, 21 &amp;25 of the Quiz correctly.</li> </ul>			Refer to pages 22-31 of the ‘Supporting Information’. Conduct an inservice education session if required.
<ul style="list-style-type: none"> <li>• know the major risks associated with the use of paracetamol and NSAID’s;</li> <li>• describe the basic approaches to the management of potential side effects of opioids such as sedation, constipation and nausea and vomiting;</li> <li>• direct care staff to monitor for side effects, and explain the common side effects;</li> <li>• answer questions 7,8,9,11, &amp; 31 of the Quiz correctly.</li> </ul>			Refer to pages 22-25 of the ‘Supporting Information’. Conduct an inservice education session if required.
Describe the 3 categories of ‘goals of care’ that could apply to any resident.			Refer the nurse to page 8 of the ‘Guidelines’ for information relating to goals of care. Conduct a short inservice education session if required.

## PHYSICAL EXAMINATION OF THE RESIDENT FOR PAIN

### Registered and Enrolled Nurses

#### Assessment methods:

O = Observation; D = Demonstration; R = Review of resident records; V = Verbal description; W = Written response.

Competency	Assess Method	Date	Met = M Not Met = NM	Signature of assessor	For information refer to:	Follow up if 'not met'			
						Assess method	Date	Met = M Not Met = NM	Signature of assessor
RN prepares the resident: obtains consent, positions resident correctly					Guidelines page 18				
When resident positioned RN tries to ascertain whether the resident can self-report pain					Guidelines page 18				
RN can demonstrate the procedure for systematically visually inspecting, palpating and moving the resident to complete a physical assessment.					Guidelines pages 18-20				
RN can describe signs that may indicate pain while the assessment is in progress					Guidelines pages 18-20				
RN correctly documents the findings and reports the findings to the appropriate people per the facility policy					Facility policy				

## SECTION THREE: QUIZ

### PAIN QUIZ ANSWERS

**For questions 1 – 12 please circle the correct response:**

1. The most accurate way to assess if a resident has pain is:
- For all the nurses to observe the resident together;
  - To monitor the resident's vital signs for any changes;
  - To ask the resident if she has any pain.

**See page 12-13 of the “Supporting Information”**

2. ‘Aching’ and ‘throbbing’ commonly describe which type of pain?
- visceral;
  - somatic;
  - neuropathic;

**See page 9 of the “Supporting Information”**

3. ‘Burning’, ‘shooting’ and ‘tingling’ commonly describe which type of pain?
- somatic;
  - neuropathic;
  - nociceptive.

**See page 9 of the “Supporting Information”**

4. A co-analgesic / adjuvant analgesic drug should be commenced:
- When breakthrough pain is occurring;
  - When the resident is depressed;
  - When there are specific indications;
  - When the resident becomes addicted to opioids.

**See page 24 of the “Supporting Information”**

5. A resident is on step two of the WHO analgesic ladder, and is receiving two Panadeine Forte tablets four times per day for pain. You assess him and decide his medication needs reviewing as he is still experiencing persistent pain. Which is the most appropriate option:
- increase the dose of Panadeine Forte;
  - replace the Panadeine Forte with Tramadol and paracetamol;
  - replace the Panadeine Forte with morphine and paracetamol;
  - replace the Panadeine Forte with codeine and an NSAID.

**See page 21 of the “Supporting Information”**

6. Your resident is receiving 5mg of oral immediate release morphine every four hours, with good pain relief. What dose of modified release morphine would he require?
- 15mg once per day;
  - 15mg twelve hourly;
  - 30mg twelve hourly;
  - 45mg once per day.

**See page 21 of the “Supporting Information”**

7. Which of these common side effects from opioids tends to persist throughout treatment?
- Constipation;
  - Drowsiness;
  - Nausea;
  - Respiratory depression.

**See page 31 of the “Supporting Information”**

8. Your resident has been commenced on a Non-Steroidal Anti Inflammatory medication (NSAID). Common risks associated with NSAID medication given to elderly people include all of the following, **except**:
- Gastric irritation and bleeding;
  - Liver toxicity;
  - Arrhythmia;
  - Renal failure;
  - Diminished platelet function.

**Refer to a MIMs or patient information leaflet**

9. Your resident has been commenced on paracetamol. One common risk associated with paracetamol given to elderly people is:
- Gastric irritation and bleeding;
  - Liver toxicity;
  - Arrhythmia;
  - Renal failure;
  - Diminished platelet function.

**See page 22 of the “Supporting Information”**

10. Your resident is to be commenced on an opioid medication. The family members are concerned that the resident will become addicted to the medication. You tell the family members the following, **except**:
- Addiction only occurs when opioids begin to lose their effectiveness;
  - Addiction usually occurs in people with a known drug habit;
  - Addiction is rare in people with pain;
  - Addiction is due to psychological dependence on the drug.

**See page 43 of the “Supporting Information”. When opioids lose their effectiveness it is tolerance, not addiction.**

11. Your resident with Lewy Body dementia is vomiting due to commencing an opioid. Which anti-emetic is the most appropriate?

- a. clonazepam;
- b. haloperidol;
- c. metoclopramide;
- d. promethazine.

**Refer to a MIMs or patient information leaflet. The older neuroleptic medications such as haloperidol may cause life-threatening adverse effects such as sedation, rigidity, falls, increased confusion and neuroleptic malignant syndrome**

12. Nursing interventions that ensure the resident will receive pain relief include all of the following **except**:

- a. Administering the amount of medication necessary, as often as necessary;
- b. Observing the resident to ensure the dose of medication was effective;
- c. Instructing the family about the medication;
- d. Stressing to the family the dangers of opioid overdose.

**For questions 13 – 32 please place a tick in the box to indicate whether the statement is true or false.**

No.		True	False
13.	It is normal for older people to have pain.		False. See page 7 of the 'Supporting Information'
14.	Pain should be suspected if a resident with dementia is aggressive.	True. See page 12 of the 'Supporting Information'	
15.	Neuropathic pain responds well to opioid medication.		False. See page 24 of the 'Supporting Information'
16.	Norspan patches are the best choice for a resident starting on opioid medication.		False. See page 22 of the 'Supporting Information'
17.	Untreated pain may cause a resident's confusion to become worse.	True. See page 8 of the 'Supporting Information'	
18.	A resident with persistent pain due to diabetic neuropathy may require an anti-epileptic drug.	True. See page 22 of the 'Supporting Information'	
19.	Immediate release morphine reaches its peak blood concentration within 30 minutes.		False. See page 26 of the 'Supporting Information'

20.	When applying fentanyl patches pressure should be applied for 15 seconds.		False. See page 25 of the 'Guidelines'
21.	If a resident cannot take an oral opioid, the best alternative route is rectal.		False. See page 28 of the 'Supporting Information'
22.	People with dementia experience less pain than people without dementia, due to damage to their autonomic nervous system.		False. See page 12 of the 'Supporting Information'
23.	Older people need smaller doses of medication because medications stay in their body longer.	True. See page 28 of the 'Supporting Information'	
24.	A behavioural pain assessment tool accurately determines the intensity of pain experienced by a resident.		False. See page 14 of the 'Supporting Information'
25.	To calculate the breakthrough dose of opioid medication required, add up the total of all opioid medication given in one day and divide by three.		False. See page 27 of the 'Supporting Information'
26.	Every resident who is suspected of experiencing persistent pain needs a pain assessment tool completed.	True. See page 14 of the 'Supporting Information'	
27.	A resident who is tachycardic may be experiencing acute pain.	True. See the 'acute pain' flowchart in the 'Guidelines'	
28.	A NOPPAIN tool should be completed after personal care is attended.	True. See p51 of the 'Supporting Information'	
29.	Breakthrough pain occurs due to a specific event.		False. See the 'incident pain' flowchart in the 'Guidelines'
30.	Providing documentary evidence of evaluation of pain interventions using an assessment tool will promote advocacy.	True. See p14 of the 'Supporting Information'	
31.	One-third of older people experience serious side effects from Tramadol.	True. See p22 of the 'Supporting Information'	
32.	A cachectic resident with dementia should not be administered subcutaneous opioid.		False. See p28 of the 'Supporting Information'

## PAIN QUIZ

**For questions 1 – 12 please circle the correct response:**

1. The most accurate way to assess if a resident has pain is:
  - a) For all the nurses to observe the resident together;
  - b) To monitor the resident's vital signs for any changes;
  - c) To ask the resident if she has any pain.
  
2. 'Aching' and 'throbbing' commonly describe which type of pain?
  - a) visceral;
  - b) somatic;
  - c) neuropathic.
  
3. 'Burning', 'shooting' and 'tingling' commonly describe which type of pain?
  - a) somatic;
  - b) neuropathic;
  - c) nociceptive.
  
4. A co-analgesic / adjuvant analgesic drug should be commenced:
  - a) When breakthrough pain is occurring;
  - b) When the resident is depressed;
  - c) When there are specific indications;
  - d. When the resident becomes addicted to opioids.
  
5. A resident is on step two of the WHO analgesic ladder, and is receiving two Panadeine Forte tablets four times per day for pain. You assess him and decide his medication needs reviewing as he is still experiencing persistent pain. Which is the most appropriate option:
  - a. increase the dose of Panadeine Forte;
  - b. replace the Panadeine Forte with Tramadol and paracetamol;
  - c. replace the Panadeine Forte with morphine and paracetamol;
  - d. replace the Panadeine Forte with codeine and an NSAID.
  
6. Your resident is receiving 5mg of oral immediate release morphine every four hours, with good pain relief. What dose of modified release morphine would he require?
  - a. 15mg once per day;
  - b. 15mg twelve hourly;
  - c. 30mg twelve hourly;
  - d. 45mg once per day.

7. Which of these common side effects from opioids tends to persist throughout treatment?

- a. Constipation;
- b. Drowsiness;
- c. Nausea;
- d. Respiratory depression.

8. Your resident has been commenced on a Non-Steroidal Anti Inflammatory medication (NSAID). Common risks associated with NSAID medication given to elderly people include all of the following, **except**:

- a. Gastric irritation and bleeding;
- b. Liver toxicity;
- c. Arrhythmia;
- d. Renal failure;
- e. Diminished platelet function.

9. Your resident has been commenced on paracetamol. One common risk associated with paracetamol given to elderly people is:

- a. Gastric irritation and bleeding;
- b. Liver toxicity;
- c. Arrhythmia;
- d. Renal failure;
- e. Diminished platelet function.

10. Your resident is to be commenced on an opioid medication. The family members are concerned that the resident will become addicted to the medication. You tell the family members the following, **except**:

- a. Addiction only occurs when opioids begin to lose their effectiveness;
- b. Addiction usually occurs in people with a known drug habit;
- c. Addiction is rare in people with pain;
- d. Addiction is due to psychological dependence on the drug.

11. Your resident with Lewy Body dementia is vomiting due to commencing an opioid. Which anti-emetic is the most appropriate?

- a. clonazepam;
- b. haloperidol;
- c. metoclopramide;
- d. promethazine.

12. Nursing interventions that ensure the resident will receive pain relief include all of the following **except**:

- a. Administering the amount of medication necessary, as often as necessary;
- b. Observing the resident to ensure the dose of medication was effective;
- c. Instructing the family about the medication;
- d. Stressing to the family the dangers of opioid overdose.

**For questions 13 – 32 please place a tick in the box to indicate whether the statement is true or false.**

<b>No.</b>		<b>True</b>	<b>False</b>
13.	It is normal for older people to have pain.		
14.	Pain should be suspected if a resident with dementia is aggressive.		
15.	Neuropathic pain responds well to opioid medication.		
16.	Norspan patches are the best choice for a resident starting on opioid medication.		
17.	Untreated pain may cause a resident's confusion to become worse.		
18.	A resident with persistent pain due to diabetic neuropathy may require an anti-epileptic drug.		
19.	Immediate release morphine reaches its peak blood concentration within 30 minutes.		
20.	When applying fentanyl patches pressure should be applied for 15 seconds.		
21.	If a resident cannot take an oral opioid, the best alternative route is rectal.		
22.	People with dementia experience less pain than people without dementia, due to damage to their autonomic nervous system.		
23.	Older people need smaller doses of medication because medications stay in their body longer.		
24.	A behavioural pain assessment tool accurately determines the intensity of pain experienced by a resident.		
25.	To calculate the breakthrough dose of opioid medication required, add up the total of all opioid medication given in one day and divide by three.		
26.	Every resident who is suspected of experiencing persistent pain needs a pain assessment tool completed.		
27.	A resident who is tachycardic may be experiencing acute pain.		
28.	A NOPPAIN tool should be completed after personal care is attended.		
29.	Breakthrough pain occurs due to a specific event.		
30.	Providing documentary evidence of evaluation of pain interventions using an assessment tool will promote advocacy.		
31.	One-third of older people experience serious side effects from Tramadol.		
32.	A cachectic resident with dementia should not be administered subcutaneous opioid.		