

# PAIN MANAGEMENT DECISION-MAKING FRAMEWORK

for nurses and care staff caring for  
people with advanced dementia

## SUPPORTING INFORMATION

## Table of Contents

Section 1	Framework Overview	3
Section 2	Pain	6
Section 2.1	Pain introduction	7
Section 2.2	Classification of pain	9
Section 2.3	Pain in advanced dementia	12
Section 3	Pain Assessment	13
Section 4	Pain Management	16
Section 4.1	Non-medication interventions for pain	18
Section 4.2	Breakthrough pain	19
Section 4.3	Analgesic and co-analgesic medications	20
Section 4.3.1	Commonly used analgesics	22
Section 4.3.2	Co-analgesics	24
Section 4.3.3	Notes on strong opioids	25
Section 4.4	Evaluation of pain management interventions	32
Section 5	Quality Improvement	33
Section 6	Capacity and Consent Issues	35
Section 7	Family Conferences	38
Section 8	Appendix	43
Section 9	References	55
Section 10	Annotated Bibliography	58

## List of Tables

Table 1	Examples of causes of acute and chronic pain	11
Table 2	Common pain behaviours in cognitively impaired older people	12
Table 3	WHO Analgesic Ladder	21
Table 4	Commencing strong opioids	26
Table 5	Oral Morphine to Transdermal Fentanyl Patch Conversion	31

## List of Figures

Figure 1	Pain Thermometer	44
Figure 2	Verbal Descriptor Scales	46
Figure 3	DOLOPLUS-2 scale	48
Figure 4	NOPPAIN scale	51
Figure 4	FACES Pain Scale	52
Figure 5	MOBID pain scale	54

## List of Appendix

Appendix 1	Commonly held myths and misconceptions about morphine and other opioids	43
Appendix 2	Pain assessment tools	44

# SECTION ONE: FRAMEWORK OVERVIEW

All health professionals must use their own professional judgement when using this framework and associated resources. Any decision to vary from this framework should be documented in the resident's records to include the reason for the variance and the subsequent action taken.

## 1.1 Introduction to the pain framework

Timely assessment and management of symptoms is a major component of a palliative approach to dementia care. This framework provides a process to adopt to assess and manage pain in residents with advanced dementia, and is based on the best available evidence, or in the absence of evidence, expert opinion.

Use of this framework will assist nurses and care staff to improve their pain assessment and management skills; and improve the well-being of residents, per Guidelines 18 and 19 (Enhanced version, 2006) of the *Guidelines for a Palliative Approach in Residential Aged Care* <sup>1</sup>.

It is recommended that in conjunction with the use of this framework, all nurses and care staff:

- refer to the pain assessment and management section within Section 6: Physical Symptom Assessment and Management in the *Guidelines for a Palliative Approach in Residential Aged Care* <sup>1</sup>;
- complete the Palliative Care Australia on-line Pain Management Module, available to support the use of the *Guidelines*, from [www.pallcare.org.au](http://www.pallcare.org.au). Select the 'Aged Care' option, then select 'Aged Care Resources', then 'Training Resources' for the *Guidelines*;
- complete the 'pain management' section of Topic 5: Symptom control, which is one topic within the Palliative Care Australia Competency unit: CHCPA01A *Deliver care services using a palliative approach*, available from Palliative Care Australia.
- complete Topic 8: promoting comfort –pain management within the Palliative Care Australia Competency unit: CHCPA02A *Plan for and provide care services using a palliative approach*, available from Palliative Care Australia.

## 1.2 Competencies required

This framework is for the use of both registered nurses and care staff within residential aged care facilities.

All nurses and care staff have a responsibility to ensure they are competent to assess and manage pain experienced by residents, within their scope of practice. Nurses and care staff who are concerned they do not have adequate levels of competency should

discuss their concerns with their managers, so that additional training can be arranged for them.

### **1.3 Scope of this framework**

The purpose of this framework is to provide best practice evidence, or in the absence of evidence, expert opinion, to enable nurses and care staff in residential aged care facilities to:

- monitor all residents with advanced dementia for pain;
- assess the resident's pain, using appropriate tools and techniques;
- treat identified pain, per the plan of care for the resident.

### **1.4 Using this framework**

All residents with advanced dementia require:

#### **1. Comprehensive pain assessment**

Complete a 'Comprehensive Pain Assessment' form (an example form is provided with the 'Guidelines' to the framework):

- within 14 days of admission to the residential aged care facility;
- annually, or whenever a review of the resident is required for Aged Care Funding Instrument (ACFI) purposes;
- whenever persistent pain is suspected; whenever there is a significant change in the resident's medical condition, such as following an injurious fall, or the diagnosis of a condition or factor associated with pain in the elderly; or if the resident self-reports unacceptable pain.

If the resident is found to have persistent pain, a pain management plan needs to be developed, in consultation with the resident if able to participate, person responsible, general practitioner and the multidisciplinary care team.

#### **2. Continuous monitoring until the pain is settled**

All residents with advanced dementia require the interventions used to manage pain to be continuously monitored and evaluated, using a 'Pain Management Record' form (an example is provided with the 'Guidelines' to the framework). Complete a pain management record form:

- for seven days (once per shift) as part of the comprehensive pain assessment;
- whenever the resident has persistent pain. Complete the 'Pain Management Record' form before and after every pain intervention strategy, including analgesia, until the pain has been stable for 48 hours.

### **3. Outcome review**

The desired outcome for the resident is improved quality of life. The goal is that the individual resident, and/or their person responsible, and the care team, should be able to verbalise satisfaction that the resident's pain has been managed to an acceptable level. To successfully achieve this goal:

- Observe the resident daily as part of routine care, and act on any signs of discomfort. A pre-determined limit for example, a score > 3 on a 0-10 self-report scale, or score >5 on the Doloplus-2 scale, should trigger a pain assessment. If in the clinical judgement of the assessor, an intervention is required then both the intervention and an evaluation of the outcome should be recorded on the 'Pain Management Record' form;
- discuss the possibility of the resident having pain at meetings and nurse handovers;
- sign the 'Weekly Outcomes Review' after consultation with family members and members of the care team.

## **1.5 Responsibility, Accountability and Advocacy**

All nurses who are involved in pain assessment and management of residents should be aware of the contents of this framework; and that they should act within the standards of conduct of their profession. National competency standards for registered nurses are available from the Australian Nursing & Midwifery Council <sup>2</sup>.

Registered nurses remain accountable for the work of assistants in nursing / personal care attendants if they delegate aspects of pain assessment and management to them.

Resident's with advanced dementia are among the most vulnerable people in our community, and as such require all nurses and care staff to advocate on their behalf so they receive appropriate best practice pain management. As an advocate for the resident, nurses and care staff must take all reasonable means to alleviate the resident's suffering and improve the resident's quality of life. Collaboration with other members of the care team, the general practitioner and family members, is required as part of advocacy, as is referral to other clinicians. Preparation for consultations with visiting clinicians, including collecting all the available evidence relating to the resident's pain management (such as medical files, pain assessment charts, bowel charts and the like); and being available to review and discuss the resident with the visiting clinician are all necessary tasks associated with resident advocacy, to facilitate the best possible care for the resident.

If a resident remains in pain despite the best efforts of the care team, it is quite reasonable for nurses and care staff to request assistance from more senior facility management staff to ensure an acceptable outcome for the resident.

Additionally, nurses and care staff have an obligation to identify when their facility's policies, procedures and practices require reviewing so that consistent effective pain management processes are available for every resident, including those residents unable to self-report their own pain.

## SECTION TWO: PAIN

### KEY POINTS

- Pain is an unpleasant subjective sensation that can only be experienced by the individual: pain is what the person says it is;
- maintain a high index of suspicion that residents with advanced dementia have unreported or undetected pain;
- treat pain promptly when it is suspected; use both medication and non-medication interventions as indicated;
- if pain appears mild or transient or the resident appears uncomfortable, try simple non-medication interventions first;
- if non-medication interventions do not improve the resident's comfort, give a simple analgesic (refer to the resident's medication chart and local facility policy);
- if regular analgesic medication is ordered a breakthrough dose must also be ordered and given if required;
- if an opioid medication is commenced, a laxative **MUST** be routinely commenced as well;
- trial analgesics before resorting to psychotropic medication, especially in residents who are aggressive or resistive to care;
- always evaluate all interventions continuously until the pain has been stable for 48 hours.

## **2.1: INTRODUCTION**

### **Pain and suffering**

Pain is an unpleasant subjective sensation that can only be experienced by the individual. Suffering is multidimensional, having physical, psychological, social, cultural and spiritual components. Each of these components, if present, can impact on and multiply the effects of the others. Individuals can suffer from either one, or multiple, types of pain at any one time, therefore the assessment, management and outcome of any pain relief interventions must reflect this fact.

The threshold for pain, that is, the point at which increasing intensity of stimuli is felt as painful, can be lowered by factors such as discomfort, fatigue, anxiety, fear, depression, feeling abandoned, and boredom. The threshold for the perception of pain can be raised by providing relief of other symptoms, sleep, companionship, diversional activity, empathy, and providing the appropriate medication for the pain.<sup>3</sup>

### **Pain in older people**

Helme and Gibson (2001)<sup>4</sup> found when they reviewed the available epidemiological research into pain in older people that the greatest prevalence of pain in this cohort is due to the amount of degenerative joint disease and spine disease, coupled with leg and foot disorders, experienced by older people. Head, abdominal and chest pain frequency reduces among older people, while musculoskeletal joint pain increases slowly until at least 80 years of age. Age-related back pain probably peaks in late middle age or early old age and declines in very old age<sup>4</sup>. Acute pain exacerbations in older people are frequently associated with cancer, fractures and infections<sup>4</sup>.

### **Pain prevalence in residents living in residential aged care facilities**

There is a high prevalence of persistent pain in residents living in residential aged care facilities, with up to eighty percent of residents affected<sup>5</sup>, and many barriers to successful management of pain noted<sup>1, 6</sup>. For residents who are cognitively impaired, two frequently held cultural beliefs act as additional barriers to pain management. These are that nothing can be done about pain in residents with dementia; and that residents with dementia do not experience pain and therefore don't require analgesics<sup>7</sup>.

Contrary to these beliefs, evidence shows that residents with dementia do experience pain and this pain can be assessed, treated with medications and non-medication interventions and the outcome evaluated, leading to improved quality of life for the resident.

## **Consequences of Untreated Pain**

Inadequate pain assessment and management can lead to restricted participation in activities and decreased socialisation, gait disturbances, falls, poor nutrition, further decline in cognition, polypharmacy, agitation, restlessness, depression, sleep disturbances, malnutrition and decreased quality of life.<sup>8</sup>

## 2.2: CLASSIFICATION OF PAIN

There are various classifications of pain, including those described due to their aetiology (cause); or the body system affected. Other classification systems include the pathophysiological and temporal systems. A brief outline of the latter systems is included here.

### 1. Pathophysiological classification of pain

- **Nociceptive pain:**

**Somatic.** Pain from skin, muscles, tendons and bone. Occurs as a result of activation of nociceptors in cutaneous and deep tissues and is well localised, eg bone pain. This is the most common type of pain experienced by elderly people.

**Typical Descriptors:** ACHING, SHARP, GNAWING, THROBBING

**Typical Causes:** Metastases, post surgical, musculoskeletal, inflammation. Conditions such as rheumatoid arthritis, osteoarthritis, gout, mechanical neck and back pain syndromes, fibromyalgia, ischaemic limb pain <sup>9, 10</sup>.

**Visceral.** Pain from the viscera, ie heart, stomach, gut, liver, uterus, pancreas, lungs etc. Commonly seen in the cancer patient. Can be referred to cutaneous sites and is often associated with tenderness in the referred site, eg shoulder pain from diaphragmatic irritation. It is poorly localised.

**Typical Descriptors:** DEEP, SQUEEZING, PRESSURE

**Typical Causes:** Infiltration, distension, liver, pancreas

- **Neuropathic pain:**

This is the second most common type of pain experienced by older people. It results from injury to the peripheral and / or central nervous system.

**Typical Descriptors:** BURNING, SHOOTING, RADIATING, TINGLING, NUMBNESS, 'PINS & NEEDLES', DEEP ACHING.

**Typical Causes:** Diabetic neuropathy, post-stroke pain (central, peripheral), compression, infiltration, anti-cancer treatment, postherpetic neuralgia, phantom limb pain <sup>9, 10</sup>.

In older people, a mixed syndrome of pain may also be found. These syndromes include headaches <sup>10</sup>.

## 2. Temporal classification of pain

**Acute pain** is generally of sudden onset, may be severe, and is of brief duration. Acute pain responds well to analgesia and has a predictable ending<sup>11</sup>. It is associated with signs of autonomic activity, which include sweating, tachycardia and nausea, as well as behavioural signs such as grimacing, rubbing the affected area, or protecting or resting the painful area <sup>5</sup>.

**Chronic pain** is prolonged pain, usually lasting more than three to six months. Chronic pain is more difficult to detect in a non-communicative resident. Autonomic signs are absent, the pain may be difficult to localise, there may be no behavioural reactions until the resident moves and then behavioural signs such as grimacing are seen. Tenderness in response to touch may also indicate an underlying chronic pain problem <sup>5</sup>.

**Incident pain** results from a specific event such as having a wound dressed, or being transferred from bed to chair. Incident pain requires treatment in the form of analgesics, to be given prior to the event that causes the pain <sup>6</sup>.

**Breakthrough pain** occurs between regular doses of an analgesic, and is most commonly associated with cancer pain<sup>1, 6</sup>. The usual response is to give an extra or 'breakthrough' dose of the analgesic ordered <sup>12</sup>, and review the medication if repeated breakthrough doses are required.

**Acute-on-chronic pain** is well-controlled chronic pain with the addition of a new pain, which will require separate evaluation and treatment.

Table 1 (overleaf) gives some examples of causes of acute and chronic pain.

**Table 1: Examples of causes of acute and chronic pain**

<b>Area of Examination</b>	<b>Examples</b>
Musculoskeletal	Arthritis Osteo arthritis Rheumatoid Arthritis Gout Degenerative lower back pain Cancer metastatic to bone Contractures
Neurological	Herpes Zoster Peripheral Neuropathy Diabetic Neuropathy Cardiovascular Cancer due to direct nerve compression
Gastroenterology	Constipation Diarrhoea Cholecystitis Pancreatitis Cancer metastases to liver Colitis
Cardiovascular	Angina
Respiratory	Excessive use of respiratory muscles – viral, post infective Pleurisy- viral, post-infective
Urinary	Urinary Tract Infection Acute Retention
Mouth	Dental conditions
Psycho-social issues	Mood disorders

## 2.3: PAIN IN ADVANCED DEMENTIA

Cognitively impaired residents in aged care facilities are prescribed fewer analgesics by their doctors, and given fewer analgesics by nurses, than cognitively intact residents.

Evidence that people with Alzheimer’s disease suffer less pain than people without dementia is disputed 9. Central Nervous System changes that occur with dementia may influence or diminish interpretation of pain transmission, but at this time this cannot be confirmed 13. Snow notes that:

*“it is highly unlikely that persons with dementia ever become so impaired as to lose all pain perception”* 14 (p2) .

For this reason, it is wise to maintain a high index of suspicion that residents with advanced dementia have unreported or undetected pain 9.

### Behavioural indicators of pain

The behaviour of residents who cannot self-report their own pain will need to be monitored carefully, as changes to behaviour may be the only indication that pain is present.

**Table 2: Common pain behaviours in cognitively impaired older people**

<b>Facial Expressions</b>	Slight frown; sad frightened face Grimacing, wrinkled forehead; closed or tightened eyes Any distorted expression Rapid blinking
<b>Verbalisations, Vocalisations</b>	Sighing, moaning, groaning Grunting, chanting, calling out Noisy breathing Asking for help Verbally abusive
<b>Body Movements</b>	Rigid, tense body posture, guarding Fidgeting Increased pacing, rocking Restricted movement Gait or mobility changes
<b>Changes in Interpersonal Interactions</b>	Aggressive, combative, resisting care Decreased social interactions Socially inappropriate, disruptive Withdrawn
<b>Changes in Activity Patterns or Routines</b>	Refusing food, appetite change Increase in rest periods Sleep, rest changes Sudden cessation of common routines Increased wandering
<b>Mental Status Changes</b>	Crying or tears Increased confusion Irritability or distress

Source: The American Geriatrics Society (AGS) Panel on Persistent Pain in Older Persons, Clinical Practice Guideline, 2002. *Journal of the American Geriatrics Society*, Vol 50. pp 5205-5224 p.211, Table 3.

## SECTION THREE: PAIN ASSESSMENT

### Specific considerations for assessing and managing pain in residents with advanced dementia

- A team approach is needed to assess pain in residents with advanced dementia;
- any condition that is painful for a cognitively intact person can be assumed to be painful for a cognitively impaired person <sup>15</sup>;
- residents with advanced dementia will never be able to ask for breakthrough medication. If a painful condition is known to be present, the resident will require regular assessment to ensure that the pain management remains adequate <sup>7, 16</sup>;
- allow extra time for assessment of cognitively impaired residents. They take longer than cognitively intact residents to respond to questions <sup>5, 17</sup>;
- residents with advanced dementia may be disinhibited due to the disease, and as a result may “act out” and appear to have more pain than is actually present <sup>18</sup>;
- some cognitively impaired people will display significant numbers of behaviours and be distressed by suffering from causes other than pain. Others will have severe pain and display few behavioural signs;
- recent research indicates that aggressive cognitively impaired people are significantly more likely than a non-aggressive cognitively impaired person to have a diagnosis of arthritis, or have 2 or more pain related diagnoses <sup>19</sup>, including strokes, contractures and pressure ulcers;
- some forms of dementia seem to mute facial expression, while others appear to have no impact on facial expression <sup>15</sup>. However, even in very end stage dementia, fragments of facial expression may remain, such as happy, sad or angry <sup>20</sup>. These expressions can be used to assist in determining whether the resident is comfortable. Current research indicates that facial expressions are an accurate means for assessing the presence of pain but not the intensity of pain <sup>20</sup>;
- proxy assessment is required if the resident is unable to communicate. Proxy assessment may be unreliable. Research with cognitively intact people has indicated that physicians and registered nurses tend to underestimate pain severity when making proxy assessments, and family members tend to overestimate pain severity <sup>9, 15</sup>;
- family members may assume a person with end stage dementia has no pain, because the person with dementia appears non-responsive <sup>7</sup>.

There are numerous pain assessment tools available for people able to self-report their pain, and behavioural observation tools for cognitively impaired people unable to

verbally communicate. The gold standard for pain assessment is self-report, so if a resident can comprehend an assessment tool and complete it themselves, that tool should be used. It should be noted that older people have more difficulty using self-report scales properly than younger people <sup>21</sup>. Notwithstanding this difficulty, a trial of a self-report scale should always be undertaken before moving to an observational behavioural tool.

A systematic review completed in 2006 <sup>22</sup> of twelve currently available behavioural pain assessment tools found that most scales are still under development and show moderate ability to identify pain. No behavioural observation tool is able to identify the intensity of pain in a severely cognitively impaired individual<sup>9, 23</sup>, so measures of ‘mild’, ‘moderate’ or ‘severe’ pain cannot be made unless residents are able to describe their pain themselves.

A comparison between two behavioural observation tools (Abbey Pain Scale <sup>24</sup> and PAINAD <sup>25</sup>) and physician examination was undertaken in 2008 in Western Australia <sup>26</sup>. Twenty-two residents with moderate to severe dementia were assessed for pain, using the tools or physician examination. The physician found that 15 (68%) had pain. The Abbey Pain Scale identified 3 of the residents with pain (13.6%); and the PAINAD identified 6 of the 22 residents (27%). The fact remains that there is no short cut to identification of pain in residents unable to communicate verbally. Clinical judgement, the resident’s known medical history, and physical assessment are all required to confirm pain in a resident unable to communicate discomfort verbally <sup>14, 27</sup>.

Despite the deficiencies in the properties of the various tools, they should still be used. The assessment of pain is more subjective without using a tool than with one. Repeated use and documentation of scores from a tool provide evidence that assists the health practitioner to judge the effectiveness of the pain intervention, and the need to make adjustments to the treatment regime. That is, using an assessment scale is most useful to monitor the effectiveness of interventions rather than the initial diagnosis of pain.

Examples of pain assessment tools are available in the Appendix to this document, and procedures describing how to complete a tool are available in the framework ‘Guidelines’.

## **When To Assess Pain In A Resident With Advanced Dementia**

The Australian Pain Society Residential Aged Care Pain Management Guidelines (Section 2:10) <sup>9</sup> note that:

*“it is inappropriate, intrusive and wasteful of scarce clinical resources to initiate a time-consuming comprehensive assessment if pain is mild, transient, short-lived, self limiting or easily relieved with simple measures and generally, not bothersome. A pain-vigilant culture will facilitate future assessment if pain becomes more troublesome.”*

Any pain that is persistent, and is impacting on residents’ functional ability, psychosocial function, or affecting their comfort needs immediate attention <sup>28</sup>.

A comprehensive assessment, using a form such as the 'Comprehensive Pain Assessment' form included in the framework '*Guidelines*' should be completed to obtain baseline information, and guide future pain management.

All residents with advanced dementia require a comprehensive assessment to be completed:

- within 14 days of admission to the residential aged care facility;
- annually, or whenever a review of the resident is required for ACFI purposes;
- whenever persistent pain is suspected; whenever there is a significant change in the resident's medical condition, such as following an injurious fall, or the diagnosis of a condition or factor associated with pain in the elderly; or if the resident self-reports unacceptable pain.

If the resident is found to have persistent pain, a pain management plan needs to be developed, in consultation with the resident if able to participate, person responsible, general practitioner and the multidisciplinary care team.

Continuously monitor a resident with persistent pain until the pain has settled. Use the pain assessment tool best suited to the resident, and evaluate each intervention strategy until the pain has been settled for 48 hours. Use the 'Pain Management Record' form provided with this framework, or the facility pain management record form if suitable, to record observations.

The following situations may indicate new pain, or the need to titrate the dose of current medication, or change the medication. The presence of these triggers should be the sign that continuous pain monitoring of the resident is needed:

- when the resident self-reports unacceptable pain;
- when there is a change in the resident's behaviour (either an increase or decrease in usual patterns of behaviour); or
- when care staff note pain while undertaking personal care (eg grimacing when limbs being moved); or
- when a new behaviour is noted, especially aggression or resistiveness to care; or
- when a painful procedure is being undertaken, such as wound care; or
- when the resident appears to be physically unwell, with sweating, tachycardia, or fever.

To improve the comfort and quality of life of residents with advanced dementia, discuss the possibility of pain within the care team, and observe the resident daily. Review the outcomes weekly and record on the 'Outcomes Review' Form, or a similar form if the facility has one. A copy is available in the framework '*Guidelines*'.

# SECTION FOUR: PAIN MANAGEMENT

## Goals of pain management for every resident

Before beginning any strategies for managing persistent pain in a resident, it may be useful to state in the resident's notes and on the pain management plan a simple measure or goal for each resident's pain management, such as 'decreased agitation' or 'sleeps through the night' <sup>29</sup>.

Each resident's situation is different. The family members of a resident with very end stage dementia may prefer that the goal of pain management be to totally eradicate any signs of pain, even if it means the resident is sedated.

For a resident who has severe dementia, who is still able to walk around, the aim of the pain management strategies may be to reduce the pain to tolerable levels, so that mobility and independence can be maximised <sup>5</sup>. It may be unrealistic to expect that this resident will be 100% pain free all the time.

A resident requiring wound care may require analgesia for incident pain prior to the care being given. The resident / family members may prefer that less analgesia is given at the time of the wound care, which may last for only 2 or 3 minutes, versus the resident remaining sedated for a number of hours after the procedure.

When reviewing the pain outcomes for the resident every week, refer to the goal of pain management before discussing with the resident / family members / other staff whether they are satisfied that the outcomes have been reached.

## Key points associated with pain management

- If pain appears mild or transient or the resident appears uncomfortable, try simple non-medication interventions first;
- if pain is suspected, and non-medication interventions do not improve the resident's comfort, give a simple analgesic (refer to the resident's medication chart and local facility policy if no 'as necessary' medication is ordered. The general practitioner may need to be contacted for an order);
- investigate the possible pain more thoroughly. Refer to the flowcharts for incident pain, chronic pain and acute pain available in the 'Guidelines' that are provided with this document;
- report the findings to the general practitioner, and document in the resident's notes;
- if regular analgesic medication is ordered a breakthrough dose must also be ordered and given if required;

- if commencing a new medication, or changing the dosage of a medication, always 'start low, and go slow' to minimise side effects;
- if an opioid medication is commenced, a laxative **MUST** be routinely commenced as well.

## 4.1: NON-MEDICATION INTERVENTIONS FOR PAIN

Non-medication interventions aimed at settling an uncomfortable or distressed resident should be utilised whenever distress is noted. Interventions can be implemented either alone or in combination with analgesic medications. For a new behaviour, or a change in existing behaviour, try at least one of the following interventions, and evaluate it 30 minutes later, before using a medication. Non-medication interventions that have been used successfully include:

- communicating in a soothing and supportive way;
- gently touching the resident;
- repositioning the resident;
- toileting the resident;
- offering food or fluids;
- managing environmental stimuli such as noise, light;
- attending to and adjusting or changing poorly fitting shoes and clothes;
- using music, or massage <sup>15, 30</sup>. Massage has been shown to lower pain and anxiety scores and increase the ability to communicate <sup>31</sup>;
- aromatherapy may be useful;
- diversional activities and distraction may also assist the resident;
- use a multi-sensory room to calm the resident;
- exercise may have beneficial effects, but may be difficult to supervise <sup>9</sup>.

### Application of hot or cold packs for pain

The use of hot or cold packs for a cognitively impaired resident may be inappropriate, due to the resident's inability to report burning. Before considering the use of a hot or cold pack:

- refer to local facility policies; and/or
- refer to NSW Health Policy (C97/129) (GL2005\_015); and
- discuss with the general practitioner, and other appropriate clinical staff.

General principles relating to the use of hot or cold packs <sup>32</sup>:

- assess the sensory status of the resident and the condition of the resident's skin prior to use;
- regularly monitor the resident while the hot or cold pack is in use;
- ensure the hot or cold pack has a cover so that it is not directly in contact with the resident's skin;
- continuous application should not exceed 20 minutes; less may be appropriate for a frail resident;
- stop the treatment immediately if any adverse signs are noted;
- record in the resident's notes the site and time of commencement of the hot or cold pack treatment; record the duration of the application and the condition of the resident's skin on cessation of the application;

- commercially available heating or cooling devices should comply with the relevant Australian Standard where this exists and be used in compliance with the manufacturer's instructions and locally developed policies. The subject list of Australian Standards for the Health Care Industry (SLO1) is available from: Standards Australia  
PO Box 1055,  
Strathfield NSW 2135. Telephone: 02 9746 4700 Facsimile: 02 9746 3333

Facility staff are to refer to other services whenever necessary if pain is not controlled.

## **4.2: BREAKTHROUGH PAIN**

Breakthrough pain is pain that occurs between regular doses of an analgesic and requires an additional dose of analgesic <sup>33 (p288)</sup>, from the same or a similar class of analgesic.

A breakthrough dose should be 50% to 100% of the regular 4-hourly dose, ie one-twelfth to one-sixth of the total daily dose <sup>33 (p134)</sup> ; and taken as often as necessary, with a minimum of one hour between doses.

If a resident has 3 or more breakthrough dosages in a twenty-four hour period for non-incident pain then regular analgesics should be reassessed to determine whether the analgesic dose is adequate or the appropriate analgesic is being given for the type of pain.

Use of breakthrough medication is the signal to the treating doctor that the pain treatment regime is ineffective and requires reassessment and/or titration.

Note that residents with dementia unable to self-report their own pain will require close monitoring to establish whether they require a breakthrough dose of analgesic.

## 4.3: ANALGESIC and CO-ANALGESIC MEDICATIONS

It is the responsibility of the general practitioner or other visiting medical practitioners to prescribe medication for pain management. The following information relating to medications is given to provide nurses and care staff with basic information about analgesic and co-analgesic medication that might be prescribed.

As an advocate for the resident, the nurse can suggest to the general practitioner that he or she:

- use the latest edition of *Therapeutic Guidelines for Palliative Care* if there is doubt about which medication to prescribe. Copies are available from:  
Therapeutic Guidelines Limited  
Ground Floor, 23 – 47 Villiers St  
North Melbourne, VIC, 3051  
Ph: 1800 061 260  
Fax: 03 9326 5632;
- access the opiate prescribing online learning information for GPs, available from the RACGP at:  
[www.gplearning.com.au](http://www.gplearning.com.au) It is found in the ‘Category 2’ section, under ‘aged care’;
- general practitioners may be able to telephone the on-call palliative care physician at their local Area Health Service, depending on local service agreements.

All nurses should refer to local facility policies, and NSW Health Information Bulletin 03/6937<sup>34</sup> regarding the handling of medication in high-care residential aged care facilities for further information.

Medications should be used with the least possible side effects, and for an older person the principle of ‘start low, go slow’<sup>7</sup> needs to be applied in relation to commencing medications and increasing the dosage if it is not effective. Before commencing an opioid the resident must be carefully assessed for common causes of discomfort that may be treatable by other medications or interventions. These causes include colicky pain due to faecal loading and constipation; discomfort due to bladder distension; and discomfort or pain due to pressure ulcers forming. Constipation, faecal loading and bladder distension will be made worse by the commencement of an opioid regime.

If an opioid medication regime is commenced a laxative regime MUST BE commenced at the same time.

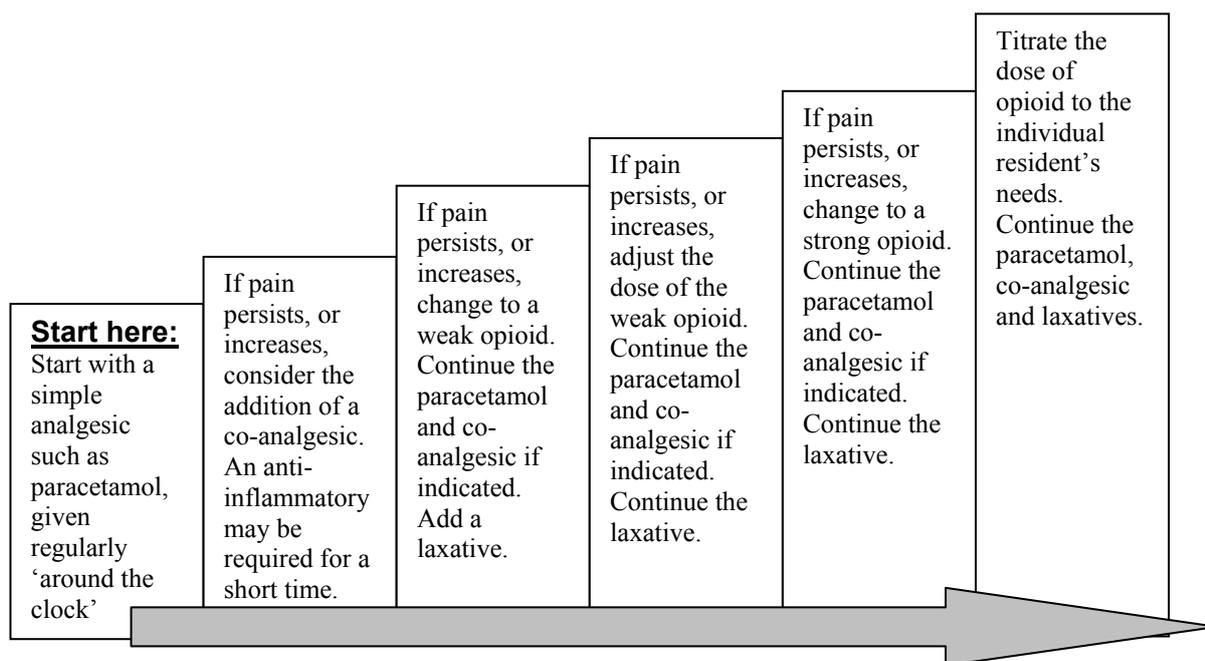
It is recommended that naloxone is available in facilities where opioids are being prescribed and used, to reverse side effects such as respiratory depression.

## World Health Organisation Guidelines

The World Health Organisation (WHO)<sup>35</sup> has provided guidelines for pain management (see Table 3: WHO analgesic ladder, below). Medications should be administered in standard doses at regular intervals for persistent pain, with simple analgesics such as paracetamol being used in the first instance. If pain is not controlled, the dose is adjusted, or a co-analgesic such as an antidepressant commenced in combination with the paracetamol until the pain is controlled. A combination of medications may be better tolerated than one high dose of a single drug <sup>11</sup>. For example, giving a frail elderly person controlled-release morphine 2mg twice daily, together with nortriptyline 10mg at night for post-herpetic pain may be more effective than giving a larger dose of either medication, which could lead to an increased number of adverse effects <sup>36</sup>.

**Table 3: WHO Analgesic Ladder**

‘Start low and go slow’.



In the absence of self-report of pain, any resident who is suspected of having pain should have a trial of analgesics commenced and evaluated. Start at the bottom of the WHO ladder and move up the steps as indicated by the resident’s condition.

### 4.3.1 Commonly used analgesics

*This information is for the interest of nurses and care staff, and is not meant to be used as a basis for prescribing analgesia.*

- **Simple analgesics eg paracetamol.**

Paracetamol is the analgesic at the bottom rung of the WHO ladder, and is the preferred analgesic for an older person with musculoskeletal pain. A typical dose in an older person would be 15mg / kg of body weight, with a maximum daily dose of 1G. Paracetamol may be given orally or rectally. There is a risk of liver toxicity with paracetamol, so the maximum dose should not be exceeded. Refer to NSW Health Policy Directive PD2005\_304<sup>37</sup> for further guidance for health professionals in the use of paracetamol.

- **Weak Opioids**

NB all orders of opioid medication require a laxative to be ordered at the same time.

**Buprenorphine** (eg *Norspan* transdermal patches): Despite being classified as a weak opioid, a 5mg buprenorphine patch is equivalent to 10mg of morphine per day. Buprenorphine should not be commenced in a resident who has never been given opioid medication before (opioid naïve). Therefore, a resident should be commenced on a small regular dose of an opioid such as oral morphine 1mg, or *Oxy-Norm* 1mg, and evaluated to see whether side effects develop, before considering commencing buprenorphine. If a frail resident is commenced straight onto buprenorphine patches there is a real possibility of respiratory depression and drowsiness being experienced, which will require repeated doses of naloxone to reverse. If the resident is able to tolerate the doses of oral morphine or *Oxy-Norm*, then they can safely be commenced on an equivalent dose of buprenorphine. Buprenorphine patches are changed every seven days. Side effects include respiratory depression, constipation, dizziness, confusion, itch, skin reactions at the application site, and headache.

**Codeine phosphate:** Codeine phosphate is also classified as a weak opioid, but it should be remembered that it has approximately one eighth the potency of oral morphine. Therefore, a typical dose of codeine phosphate 30mg fourth hourly is equivalent to almost 4mg oral morphine fourth hourly, so a resident receiving this medication should be assessed regularly for drowsiness. Caution is required when giving codeine phosphate to residents with renal failure and hypothyroidism.

**Tramadol:** tramadol is also classified as a weak opioid, the conversion rate to oral morphine is variable with tramadol having approximately one-fifth the potency of oral morphine, although the potency varies depending on the liver function of the person taking it. Up to one third of older people cannot tolerate tramadol. It may have serious side effects such as delirium and hallucinations, and cause postural hypotension. Other side effects include nausea, vomiting, constipation and seizures. If a resident is to be commenced on tramadol for chronic pain, a starting dose of 50mg in the evening is appropriate, with the dose increased slowly by 50mg per day until the desired dose

is reached. If the resident requires continued tramadol for pain, a slow release tablet is available.

- **Strong opioids**

(More information about the use of strong opioids is provided later in this section).

**Morphine:** In an opioid naïve resident with dementia (ie a resident who has never even been given regular *Panadeine Forte* or similar), the starting dose of oral morphine should be 1mg to 2mg, with doses three times per day or four times per day often sufficient, rather than the more traditional dose of every four hours. An order for a breakthrough dose of oral morphine can be used if required to supplement the regular order until the pain is stable.

Morphine is available in sustained release forms, eg *MS Contin* tablets; *MS Mono* tablets and *Kapanol* capsules. *MS Contin* and *MS Mono* must not be crushed or broken in half. Similarly, *MS Contin* oral suspension sachets should not be reconstituted and then a half or quarter dose given due to the inability to gauge whether an accurate dose has been given. Controlled release tablets can be used rectally at the same dose <sup>33 (p136)</sup>.

*Kapanol* capsules can be opened and the pellets mixed with soft food if necessary.

Side effects of morphine include sedation, gastrointestinal system upsets, sweating, respiratory depression, seizures, constipation and hypotension.

**Oxycodone:** Oxycodone may have less adverse CNS effects than morphine, and be useful in delirium and cognitive impairment. Residents with dementia being commenced on oxycodone should be given a small dose eg *Oxynorm* 1mg four times per day (6 hourly) or 1mg every four hours, with a breakthrough dose available, and observed carefully to see how they react to the medication. Controlled release tablets are available, but should not be used until the resident has been trialled on an immediate release preparation.

Side effects of immediate release oxycodone include constipation, nausea, vomiting, confusion, hallucinations and twitching; sustained release forms of oxycodone also may cause respiratory depression, hypotension, bronchospasm and rash.

**Fentanyl:** fentanyl patches are not appropriate for opioid-naïve residents with non-cancer pain. Therefore, if fentanyl is to be used, the resident should be trialled on a small dose of immediate release oral morphine before changing to fentanyl. If fentanyl is commenced, the smallest patch (12mcg/hr) should be used and the resident observed carefully for sedation and respiratory depression. Repeated doses of naloxone will be required to reverse any adverse effects that occur. See additional notes later in this section on the use of fentanyl; and refer to the procedures section of the framework '*Guidelines*' for the correct procedure when applying fentanyl patches.

**Hydromorphone:** For an opioid-naïve resident, 1mg hydromorphone given four-hourly is equivalent to 4mg of morphine four-hourly, therefore hydromorphone needs to be commenced with caution, especially in a resident with reduced glomerular-filtration rate (renal impairment). For an elderly resident with dementia a starting dose of hydromorphone could be 0.5mg three times a day. Side effects include respiratory depression, constipation, other gastro-intestinal tract upsets, sedation, dizziness and sweating.

### 4.3.2 Co-analgesic medications

Co-analgesic medications (also called adjuvant medications) relieve pain in specific circumstances<sup>38</sup>, when pain does not respond to even high doses of opioids. They can be used in combination with opioids, and should usually be commenced at a low dose and the dose increased gradually. This group includes non-steroidal anti-inflammatory drugs, anti-convulsants, tricyclic anti-depressants and corticosteroids. The appropriate co-analgesic must be chosen to suit the type of pain being experienced<sup>38</sup>. Regular assessment of the resident is required before and during treatment with co-analgesics to monitor the effectiveness of the treatment. The co-analgesic should be trialled for a number of weeks before the drug is stopped if it is ineffective, and a new co-analgesic trialled<sup>38</sup>.

- **Anti-inflammatory analgesics eg Non-steroidal anti-inflammatory medications; Cox-2-Selective medications**

These medications should be used for very limited periods, if at all, in an older resident with dementia who is unable to report symptoms, due to the high risk of peptic ulceration, perforation and haemorrhage. Medications should be used with extreme caution in residents with congestive cardiac failure and renal failure.

- **Anticonvulsants**

**Gabapentin** is an anti-epileptic drug, useful for neuropathic pain. Gabapentin is purely excreted by the kidneys, much lower doses are required for older people and people with kidney failure<sup>33 (p140)</sup>. In an elderly resident, a starting dose might be 100mg nocte, with the dose slowly increased if necessary to 100mg twice daily, then 100mg three times per day; then 300mg at night, with 100mg mane and so on. If gabapentin is discontinued, the dose reduced, or substituted with another medication, this should be done gradually over a minimum of one week<sup>38</sup>. A small change in dose of gabapentin may cause a big change in the effect of the drug, so caution is required when increasing the dose. Side effects are usually minor and subside within 4 weeks<sup>38</sup>, and include sleepiness, fatigue, ataxia, dizziness, nystagmus and gastro-intestinal upsets.

**Pregabalin** (eg *Lyrica*) is also an anti-epileptic drug useful for neuropathic pain. Starting dose should be 75mg nocte for an elderly resident with dementia, then the dose slowly increased to 75mg twice daily, then 150mg nocte etc.

**Valproate** (eg *Epilim*) is also an anticonvulsant useful for neuropathic pain, especially shooting or stabbing pain. It must be taken with food. A starting dose for an elderly resident with dementia should be no more than 50mg once or twice daily. The dose can be slowly increased to a maximum dose of 500mg twice daily. Blood pathology tests need to be taken within two weeks of starting valproate tablets; failure to do so may result in legal action. Side effects include pancreatitis, hyperglycaemia, and liver dysfunction.

- **Tricyclic Antidepressants**

**Nortriptyline** is useful for neuropathic pain, especially for constant aching or burning pain. A starting dose could be 10mg nocte, as this medication may cause sedation. The dose can be increased slowly, every 3 to 7 days if required. Caution is required if using nortriptyline with residents with cardiac arrhythmia. Side effects include sedation, arrhythmia, withdrawal symptoms, dry mouth, postural hypotension, falls and urinary retention.

Note that SSRI antidepressant medications are not effective in the management of persistent pain.

- **Corticosteroids**

**Dexamethasone** is useful for pain associated with pressure from tumours. It may cause insomnia if given after 2pm, therefore divided doses should be given in the morning and at midday. The blood sugar levels of the resident should be checked regularly while on dexamethasone. A resident with pressure on nerve roots from a tumour may be given a dose of up to 16mg dexamethasone a day (in divided doses) prior to having palliative radiotherapy to shrink the tumour. After the radiotherapy, the dose would be reduced, with a maximum maintenance dose of 4mg per day, and preferably only 2mg per day (1mg mane, 1mg at midday) if required.

### **4.3.3 Notes on the use of strong opioids**

#### **Special Medical Consent**

For residents unable to give their own consent for strong opioids, approval from the Guardianship Tribunal may be required. Strong opioids such as morphine usually require Special Medical Consent if they are prescribed for more than 10 days in 30 days, UNLESS the morphine is for treatment for pain from cancer or the palliative care of a terminally ill resident. Resident's with end stage dementia requiring morphine for pain fall in the terminally ill category; the prescribing doctor is subject to the regulations found in the Poisons Act. The 'person responsible' can give proxy consent.

#### **Commencing strong opioids**

If strong opioids are indicated to control the resident's pain, and the resident is able to take an oral medication, start with an immediate release drug such as morphine and titrate the dose until the pain is controlled. Immediate release morphine preparations

have an onset of action of approximately 20 minutes, and reach a peak around 60 minutes. Evaluate the resident 30- 60 minutes after the first dose of an opioid for effectiveness and side effects such as sedation and respiratory depression. *Therapeutic Guidelines for Palliative Care* <sup>33 (p132)</sup> note that in an elderly, cognitively impaired person, oxycodone may be preferable to morphine.

Controlled release or sustained release preparations of morphine are not suitable for acute pain or breakthrough dosing because of the time they take to reach peak blood concentrations after ingestion. Controlled-release oxycodone is effective rapidly after ingestion <sup>33 (p133)</sup>.

**Table 4: Commencing strong opioids <sup>38</sup>**

DRUG	DOSE	COMMENTS
Immediate release morphine eg <i>Ordine</i>	<p>Prescribe 4 to 6 hourly <b>and</b> ‘as required’. eg 1mg to 2mg every four hours <sup>33</sup> for an elderly resident who is opioid naïve. Continue for 24-48 hours to titrate to individual resident’s needs.</p> <p>If the dose is partially effective, in effect or duration, increase by 30% to 50%;</p> <p>if adverse effects, reduce by 30% to 50% <sup>33 (p134)</sup>.</p> <p>Order a laxative.</p> <p>Caution is required if a resident has renal impairment.</p>	<p>Additional doses can be administered ‘as required’ for breakthrough pain. Leave a minimum period of 1 hour between breakthrough doses if required.</p> <p>When titrating the dose, calculate the total amount of oral morphine used in 24 hours, including regular and breakthrough ‘as required’ doses. Divide by 6 to get the new 4 hourly and ‘as required’ dose of morphine.</p> <p>Not all pain is opioid responsive, if pain is not controlled consider co-analgesics.</p> <p>Some elderly residents with dementia may require an ‘as required’ dose only, instead of a regular dose. This is particularly relevant if the resident has incident pain that occurs at the same time each day and is due to a particular activity eg having a wound dressed. Note that the resident will not be able to ask for the medication, due to communication deficits caused by the dementia, therefore staff vigilance and assessment will be required.</p>

**CAUTION: If a dose of morphine needs to be rapidly escalated then the resident should be reviewed. The pain is probably neuropathic in origin, and increasing amounts of morphine will cause problems with side effects such as sedation, without the pain being effectively treated. A co-analgesic may be required.**

**Converting from immediate release morphine to modified release morphine**

Once pain is controlled with immediate release morphine, the resident can be converted to an equal dose of modified release morphine <sup>33</sup>. To make the conversion:

Calculate the total amount of immediate release morphine that was administered in a 24-hour period to the resident, including 'breakthrough' doses. Divide by 2 to convert to a 12-hourly slow release product eg *MS Contin*; *Kapanol*. Alternately use a once-daily dose of a slow-release medication eg *MS Mono*. Give the medication at the same time each day.

Give the first dose of these preparations at the same time as the last dose of immediate-release morphine to allow for the slow onset of action <sup>33 (p135)</sup> of the modified release product.

### **Starting a resident on modified release oral morphine**

A dose of eg 15mg modified release morphine twice daily for an older, frail resident may be better than a larger, once-daily dose and may reduce initial drowsiness and confusion<sup>38</sup> if a resident is to be commenced directly onto a modified release oral morphine product.

### **Calculating the dose for breakthrough pain when using modified release morphine**

To calculate the breakthrough dose of morphine when using a modified release product:

- total the amount of modified release morphine given in 24 hours eg resident receives 30mg modified release morphine twice daily = 60 mg in 24 hours;
- dose for breakthrough pain (one-sixth or one twelfth of the daily dose) = 60mg divided by 12 = 5mg; 60mg divided by 6 = 10mg;
- therefore breakthrough dose for pain is 5mg to 10mg immediate release oral morphine, taken 'as required'.

### **Increasing the dose of modified release morphine<sup>38</sup>**

If a resident requires breakthrough medication on a frequent basis, then their dose of modified release oral morphine should be increased to achieve pain control. Note the caution (above) that rapidly increasing doses of morphine may indicate that the pain is neuropathic in origin, and not responsive to opioids.

The new total daily dose of modified release oral morphine should be calculated by adding the total of any breakthrough doses of immediate release morphine, in a 24-hour period, to the existing daily dose of modified release morphine. A new dose of breakthrough pain medication needs to be calculated and ordered at the same time.

## Subcutaneous administration of opioids

If a resident is unable to take an oral opioid an alternative route needs to be considered. This may be either via subcutaneous injection, transdermal patch, or rectally.

Indications for subcutaneous administration of opioids:

- inability to take oral medication, such as a resident in the terminal phase of illness;
- severe nausea and/or vomiting, or bowel obstruction;
- a resident that needs a large dose of opioid.

Intermittent subcutaneous administration via an indwelling cannula such as a *Saf-T Intima* (Becton Dickinson (BD)) is less painful than intramuscular injection, and is useful for a cachectic resident with reduced muscle mass<sup>33</sup>. The framework 'Guidelines' contain the procedure for insertion of an indwelling cannula and further information, including where to order supplies.

## Syringe driver pumps

Subcutaneous administration may be delivered by a continuous infusion, such as via a *Graseby* syringe driver (Smiths Medical Australasia). An on-line self directed learning package for using *Graseby* syringe drivers is available from <http://www.cpcrc.com> ; please also refer to Appendix 1, *Therapeutic Guidelines Palliative Care*<sup>33</sup>.

Following advice from the Australian Therapeutic Goods Administration, Smiths Medical Australasia have advised they will discontinue supply of two *Graseby* syringe drivers (model numbers *Graseby* MS16a and *Graseby* MS26) from October 2007. Other models of *Graseby* syringe drivers will still be available. Existing *Graseby* MS16a and MS26 pumps will be serviced by Smiths Medical Australasia for the next five years. If a facility is considering the purchase of a pump it is recommended that other pumps than the *Graseby* MS16a and MS26 be considered. Contact Palliative Care Australia for further information. (<http://www.pallcare.org.au>)

If using a syringe driver pump, all staff responsible should know what procedure to follow in the case of a malfunction of the pump. If facility staff suspect that a pump is not working properly they should either:

- remove the pump altogether from the resident and give regular analgesia 4<sup>th</sup> hourly via the subcutaneous needle; or
- remove the battery from the pump, while keeping the pump connected to the resident, and give regular analgesia 4<sup>th</sup> hourly via the subcutaneous needle. Removing the battery will prevent the danger of the pump unexpectedly starting again, thus giving the resident additional medication.

## Calculating parenteral (subcutaneous) dose of morphine <sup>33</sup> (p137)

- When changing from oral to subcutaneous morphine, start with one-half of the 24-hour oral dose;
- for intermittent administration, give one-sixth of the calculated 24-hour dose every four hours;
- subsequent and breakthrough doses are determined as for oral morphine;
- for continuous infusion via a syringe driver, a loading dose equivalent to one-sixth of the 24-hour dose, or the last of the bolus doses if being given via intermittent subcutaneous injection, should be given at the start of the infusion;
- breakthrough doses given in conjunction with a continuous infusion via a syringe driver may be via a separate needle or via a demand bolus, depending on the type of syringe driver used.

## Transdermal Fentanyl

Fentanyl is a strong opioid, indicated for people with stable pain who have difficulty taking morphine, or other oral analgesics <sup>38</sup>. The disadvantage of fentanyl is the long delay in achieving effect after applying a patch, with a time lag of 6-12 hours to onset of action. If a resident requires less than 40mg of oral morphine per day then even a 12mcg/hr patch may deliver too much opioid <sup>39</sup>. When changing from morphine to fentanyl the resident may experience opioid withdrawal symptoms eg. abdominal cramps, sweats and flu-like symptoms, although if the changeover is well managed these symptoms will not occur. If symptoms do occur they can be abated with a dose of four hourly morphine and should only last a few days<sup>39</sup>. Fentanyl patches are generally replaced every 72 hours, they are not suitable for a resident with fever or excessive perspiration, as this can affect absorption.

Refer to the framework 'Guidelines' for the procedure for applying transdermal patches.

## Commencing transdermal fentanyl

### Resident previously being given a maximum dose of weak opioids<sup>38</sup>

Fentanyl may be considered by the medical practitioner when the resident is receiving the maximum dose of a weak opioid such as codeine ( $\geq 240\text{mg/day}$ ), (equivalent to 30mg oral morphine per 24 hours); or tramadol ( $> 300\text{mg/day}$  (in an elderly person).

- Transdermal fentanyl should be commenced with caution, using a 12 microgram per hour over 72 hours patch;
- the pre-existing analgesic being used is required for the first 12 hours after applying the patch;
- titrate the dosage to optimum pain relief only after 72 hours;
- a stimulant laxative needs to be prescribed <sup>38</sup>;
- breakthrough pain requires an immediate release opioid such as oral morphine to be administered.

## **Resident previously being given strong opioids <sup>38</sup>**

To change from a strong opioid to fentanyl:

- calculate the correct patch size using the conversion chart (Table 5), based on the resident's previous 24-hour morphine requirement;
- if converting from immediate release morphine continue to give the regular 4-hourly dose of morphine for the next 12 hours after applying the patch;
- if converting from modified release morphine, apply the first patch at the same time as giving the last 12-hourly morphine tablet;
- for breakthrough pain, immediate release opioids should be ordered 'as required'. The initial dose should be one sixth to one twelfth of the previous total daily dose of oral morphine;
- if the fentanyl patch strength is increased, the breakthrough dose should also be increased accordingly;
- if, after 48 hours on the same patch strength, a resident requires more than 2 breakthrough analgesic doses in a 24-hour period, the dose may be titrated upwards in increments of 12-25 micrograms/hr patches;
- it takes 17-24 hours to achieve stable plasma levels, therefore patch strength should not be increased at less than 48-hour intervals <sup>38</sup>.

## **Calculating the appropriate breakthrough dose while using fentanyl**

A conversion chart (see Table 5) will assist in calculating the correct dose of immediate release opioid for breakthrough pain, such as oral morphine.

## **Changing from fentanyl to subcutaneous opioid**

It is recommended that the general practitioner discuss changing a resident from fentanyl patches to subcutaneous analgesic medication with a palliative care physician, as the conversion may be difficult.

## **Side effects of strong opioids**

- **Constipation**

Constipation is almost universal when strong opioids are prescribed, and needs continuous treatment <sup>33</sup>:

- ensure the resident is receiving adequate fluids and dietary fibre <sup>33</sup>;
- a laxative should be ordered;

- monitor bowels daily <sup>36</sup>.

Residential aged care facility staff should be competent in the identification and management of constipation in residents. All bowel movements need to be accurately recorded on a bowel chart. Registered nurses and endorsed enrolled nurses should understand the different classes of laxatives, and their appropriate use.

- **Nausea and vomiting**

Anti-emetics should be used with caution because of their anticholinergic properties. Avoid metoclopramide and haloperidol use for residents with Lewy Body dementia. Domperidone is appropriate for use for nauseated residents with Parkinson's Disease dementia <sup>36</sup>.

- **Respiratory depression**

Respiratory depression is rarely a problem if doses are increased slowly. Respiratory depression may not present as a noticeable reduction in respiratory rate, but may predispose the resident to a chest infection due to poor aeration and cough <sup>33 (p 134)</sup>.

**Table 5: Oral morphine to transdermal fentanyl patch conversion chart**

Breakthrough dose oral morphine (mg)	Transdermal fentanyl patch strength (micrograms/hour)	24 hourly oral morphine equivalent (mg per day)
<10	12	Approx 45
<20	25	< 90
20 - 25	37	90 - 134
25 - 35	50	135 - 189
35 - 40	62	190 - 224
40 - 50	75	225 - 314
55 - 65	100	315 - 404
70 - 80	125	405 - 494
85 - 95	150	495 - 584
100 - 110	175	585 - 674
115 - 125	200	675 - 764
130 - 140	225	765 - 854
145 - 155	250	855 - 944
160 - 170	275	945 - 1034
175 - 185	300	1035 - 1124

From: Adult Pain Management Guidelines, 2006. Pain Management Task Group. Hull and East Riding Clinical Policy Forum <sup>38 (p90)</sup>.

## 4.4: EVALUATION of PAIN MANAGEMENT INTERVENTIONS

Continuous monitoring and evaluation of pain should occur:

- until the resident's pain is stable ie the pain is controlled for 48 hours;
- any time a new pain is diagnosed;
- every time a new analgesic is commenced;
- every time the dose of an analgesic is changed;
- every time a breakthrough dose of medication is given;
- on return of the resident from a hospital admission, for 48 hours.

Evaluation of the pain management strategy needs to occur regularly until the pain is settled. This means that:

- every dose of breakthrough medication needs to be assessed approximately 30-45 minutes after giving it; and
- every time a new dose of medication is given, or the dose changed, there should be an evaluation approximately 30-45 minutes after that dose.

Continue until pain has been stable for 48 hours. Record the results on a pain management record form, and document in the progress notes if the pain remains unsettled and the general practitioner needs to be contacted. The evaluation provides evidence of the success or failure of the pain management intervention, and will provide concrete evidence that the general practitioner can use to titrate the medication.

If pain persists after 24-48 hours, contact the general practitioner to review the appropriateness of the medication.

## **SECTION FIVE: QUALITY IMPROVEMENT**

### **Facility-wide strategies to improve pain outcomes for residents with advanced dementia**

In order to provide better outcomes for people requiring pain relief, a number of strategies may be implemented by the facility <sup>8, 30, 40</sup>. These include:

1. Form a pain working party to review ways of making the management of pain a priority within the facility.
2. Build regular monitoring of pain management strategies and evaluation into the regular quality improvement cycle in the facility.
3. Ensure staff have regular updates on pain management, programmed in to their regular education.
4. New staff need a comprehensive introduction to the pain management philosophy and practice of the facility during their orientation. Give out policies and paperwork at this time, and ensure all staff are aware of their role in the management of residents' pain.
5. It cannot be stressed too strongly that the staff who work closely with the resident on a daily, regular basis are in the best position to assess pain in a person with advanced (severe and end stage) dementia, due to their intimate knowledge of the 'normal' behaviour for that resident <sup>15</sup>. For this reason, it is recommended that staff provide a comprehensive handover to their colleagues which includes a description of the typical pain behaviours of residents, before any planned rotation of staff, or prior to transfer of the resident to another facility. This will aid in continuity of care.

### **Standards of care <sup>41</sup>:**

1. Discuss the possibility of pain daily, record pain outcomes weekly for every resident;
2. Trial and specify which assessment tool(s) to use, and how and where to document the results;
3. All staff have a role in pain assessment of a person with advanced dementia, as do the family members and other visitors who know the resident well;
4. Specify a level on a pain scale that triggers action (eg level 3 or higher on a 0-10 point scale; level 5 or higher on a scale such as the Doloplus-2 scale);
5. Residents with advanced dementia unable to self-report their pain need a short physical assessment as well as completion of the pain assessment tool;
6. Any pain that a resident reports is unacceptable to him/ her should trigger action to alleviate it;
7. Specify who should initiate pain assessment and management processes when a trigger occurs.

### **Education and Training:**

- All staff should be aware of how to assess a resident with advanced dementia for possible pain;

- all staff responsible for completing a pain assessment should be trained in the use of tools and forms;
- all staff responsible for developing or implementing pain interventions should understand the interventions;
- all family members and regular visitors should understand the pain assessment strategies being implemented, and know to whom to report possible pain for further assessment and management;
- residents who have the capacity to do so should be taught how to use a self-report pain assessment tool, and encouraged to report their own pain;
- residents or their person responsible should be involved in setting the pain control goal for the resident.

### **Quality improvement monitoring of pain outcomes 41:**

- all (100%) residents should have a comprehensive pain assessment, including a history of past pain, completed as part of their ACFI assessment.

Review and record at regular intervals:

- the % of residents whose pain outcomes are unmet during the monitoring period;
- the % of residents who are scoring >3 on a 0-10 pain scale or >5 on the Dolopus-2 scale and are not assessed further and do not have a pain intervention trialed;
- the % of residents who are prescribed regular ‘around the clock’ analgesia who do not have a breakthrough ‘as necessary’ dose of medication prescribed;
- the % of residents who are prescribed opioid medication who do not have a bowel management program also ordered;
- the % of residents with advanced dementia and changed behaviour that do not have a pain assessment undertaken prior to being given psychotropic medication.

### **Quality Improvement (QI) audits**

- consider commencing auditing with a select number (eg 5-10) resident files per month;
- summarise the results, determine whether additional education or training is required;
- if progress is satisfactory, change monitoring to quarterly and monitor a select number eg 15-20 resident files per quarter;
- if progress is not satisfactory, continue monthly audits until the results are acceptable;
- continuously monitor and summarise the results, provide feedback and further education to the care staff as necessary.

## **SECTION SIX: CAPACITY and CONSENT ISSUES**

Refer to your facilities' policies and procedures relating to consent and capacity.

### **Capacity to give informed consent.**

Before medical or dental treatment is provided to a resident, there is professional and legal responsibility to obtain consent for the treatment. Verbal consent is required: in most instances involving advanced dementia, a proxy will be required to make substitute consent (see below). Ensure that clear documentation of the consent process is made in the resident's records.

Key points relating to capacity to give informed consent<sup>42, 43</sup>:

- it is presumed that a person has the capacity to make their own healthcare decisions unless proven otherwise, (similar to the presumption of innocence until proven guilty);
- an abnormal Mini-Mental State Examination<sup>44</sup> (MMSE) score alone does not equal incapacity;
- evidence of incapacity should not be based on ignorance. The individual whose capacity is being assessed must be given relevant information;
- careful documentation is required, especially for borderline cases;
- competency to consent to medical treatment by an individual is a legal concept and legal decision, made finally by a court of law. To assess the capacity of individuals to consent to their own medical treatment is a time-consuming but necessary process.

A person who has the capacity to give consent to medical treatment should be able to:

- express in their own words what the problem is;
- express in their own words what the treatment choices are, including "do nothing";
- express in their own words what the foreseeable consequences of each treatment might be;
- all of the above must not be based on delusional ideas.

Incapacity is present if a person:

- does not know what the issue is; OR
- does not know the possible choices; OR
- does not appreciate the reasonably foreseeable consequences; OR
- the decision is based on a delusional construct; AND
- cognitive or mental impairment is present.

## **Substitute consent**

In NSW, the Guardianship Act 1987 establishes who can give valid substitute consent if an individual is incapable of doing so. A substitute decision-maker can be the 'person responsible' or a guardian: either an Enduring Guardian appointed by the person when they had the capacity to do so, or a guardian appointed by the Guardianship Tribunal.

The Guardianship Act 1987 identifies four levels of treatment: urgent; major; minor; and special treatment. Urgent treatment (aimed at saving a person's life) may proceed without valid substitute consent; all other treatment requires valid substitute consent. (See the Guardianship Tribunal website <http://www.gt.nsw.gov.au> for full details).

Key points relating to valid substitute consent:

- a 'person responsible' (in order of hierarchy) may be a guardian or enduring guardian who has the function of consenting to medical, dental or health care treatments; or the most recent spouse or defacto spouse with a close continuing relationship with the person; or an unpaid carer who is providing or was providing care to the person prior to admission to the residential aged care facility; or a relative or close friend who has close personal contact with the person;
- the 'person responsible', including an enduring guardian, cannot override a person's objections to treatment if they are objecting;
- the 'person responsible' is required to act in the best interests of the person, and needs to take the person's previously expressed wishes into account but MAY act contrary to those previously expressed views if the action is in the best interest of the person;
- for minor treatment, if the person is NOT objecting, but the person responsible cannot be located, the doctor or dentist may treat without consent <sup>45</sup>, and clearly document in the resident's notes that the treatment was necessary to promote the resident's health and well-being, and that the resident did not object. Treatment may not proceed if the person is objecting;
- a doctor may make an application to the Guardianship Tribunal to consider consent to a treatment if the guardian or 'person responsible' is objecting to the proposed treatment.

## **When is a person objecting to treatment?**

Treatment may not be instituted if the person objects.

Key points:

- objection is considered to be continuous and strenuous refusal;
- the behaviour of the individual will need to be interpreted;

- if verbally refusing, while physically doing what is required eg accepting and swallowing oral medication, but saying “no”, then that is not considered to be continuous and strenuous refusal;
- if both verbally refusing to have the treatment (eg, saying “no, no, no”) AND physically resisting the treatment (eg clenching mouth so medication cannot be given), then that is evidence of continuous and strenuous refusal. **TREATMENT MAY NOT PROCEED, EVEN IF THE PERSON RESPONSIBLE HAS GIVEN CONSENT.** The Guardianship Tribunal will need to be contacted to consent to the treatment despite the objections.

## SECTION SEVEN: FAMILY CONFERENCES

Family members require support, guidance and education when discussing and implementing any pain management interventions to ensure they understand the effects and consequences of the interventions, and to give informed consent if they are the 'person responsible'. It is recommended that they be involved, with the resident if possible, in discussing and developing the goals of pain management for the resident.

Family members can also play a vital role in identifying known pain behaviours of the resident, and providing a history of the factors that aggravate or improve pain in the resident. Their assistance should be solicited in recognising and reporting the presence of pain in a person with dementia unable to self-report pain.

Many people, including family members, hold misconceptions and fears about the use of strong opioids for pain, and require education specifically to counter the misconceptions. See Appendix 1 of this document for a discussion of the common myths and misconceptions held about morphine. Discuss the issues with family members if they are concerned prior to the commencement of the resident on strong opioids.

Palliative Care Australia have a brochure discussing opioids such as morphine available, in hardcopy and via a download from their website:  
<http://www.palliativecare.org.au> .

### **Family conferences and developing plans of care**

Planning care for a resident by holding a family conference has two-fold benefits. Firstly, by discussing the goals of care for the resident the outcomes for the resident may be improved. Secondly, relationships between all the caregivers may improve by having everyone meeting together. The general practitioner (GP) can be paid under Medicare Item Numbers 734, 736 or 738 if he or she organises and coordinates the conference, or items 775, 778 or 779 if he or she participates in a conference (not more than 5 in twelve months).

### **When to hold a family conference**

- newly admitted resident to determine the goals and plan of care;
- as part of the annual ACFI review;
- whenever an unforeseen significant change in the resident's medical condition has occurred.

## **Tips for increasing the participation of the general practitioner in family conferences**

Organising a family conference is time consuming, and it may be difficult for the general practitioner to organise, or attend. To increase the chance that the GP will participate, the following tips may be useful <sup>46</sup>:

- reduce the administrative burden on the GP. Contact the GP's surgery and try to use the Practice Manager or Practice Nurse to assist with the planning;
- try to fit the family conference in at a time when the GP is already visiting the facility;
- always give the GP the option of participating when you are organising a family conference. If he or she wants to participate, try to work out any barriers to involvement so he or she can contribute;
- offer the GP different levels of involvement eg the GP may be willing to be involved in a 10-15 minute teleconference instead of attending in person;
- when contacting the GP's office, remind the receptionist that you want to talk about one of their patients eg "I want to talk to Dr X about Mrs X" . Be specific, this may assist in getting past the 'gatekeeper';
- think about the care of the resident being the GP's responsibility, so the Practice Nurse may be useful. If you tell the Practice Nurse about concerns you have about a particular resident, and the need for a family conference, the Practice Nurse may be willing to raise the issues with the GP on your behalf;
- define the GP's role in the family conference, be very specific about what you want to achieve from the family conference. GP's prefer family conferences when they occur at specific difficult points in the disease trajectory of a resident;
- make sure all the lines of communication are clear to both GP and facility staff.

## **Steps in holding a family conference**

To ensure the GP is remunerated for his or her coordination of and participation in the family conference, the following steps are required to be performed <sup>47</sup>:

1. Identify the resident's need for a family conference;
2. Contact the GP's Practice Nurse or Practice Manager to assist with coordinating the family conference, and be the single point of contact for all attendees;
3. The Practice Nurse or Manager will consult with facility staff and determine which health professionals will be involved. NB, there must be 2 other healthcare providers present at the family conference, as well as the GP. These providers can be a nurse and a diversional therapist from the aged care facility, but could be another health service provider such as a physiotherapist, or speech pathologist, palliative care specialist or geriatrician. The other health service providers may charge a fee for their attendance;
4. Arrange a time, preferably at least 4 weeks in advance for an annual review, or as soon as possible after an unforeseen significant change in the resident's medical condition;
5. Develop an agenda and an introduction letter, the coordinator will then send these to participants;

6. The resident's consent is required, or if unable to give his or her own consent, the person responsible's consent. Verbal consent is all that is necessary. Ensure that the resident/person responsible understands there will be a Medicare charge generated for the GP's involvement, and other health service providers may also charge for their time;
7. Conduct the family conference. All members of the family conference team must participate for the whole of the conference. The conference may be face to face, or via telephone, video link, or a combination. Issues to discuss include:
  - the resident's medical history;
  - review of the previous goals and plan of care;
  - identify current multidisciplinary care needs;
  - identify the outcomes to be achieved by members of the multidisciplinary care team;
  - identify tasks that need to be undertaken in order to achieve outcomes and allocate tasks to team members;
  - identify whether previously identified outcomes have been achieved.
8. A record of the family conference must be kept in the resident's records, and a copy offered to the resident/ person responsible, and other health service providers (with the consent of the resident/person responsible).

### **What to discuss during a family conference for a resident with advanced dementia**

A number of decisions relating to the future care needs of a resident can be made in advance of their occurring, and can be included in a family conference discussion. One study<sup>48</sup> of death from dementia has revealed that:

- 85% of people with dementia die before the very end stage of dementia is reached;
- death, regardless of when it occurs, is most commonly associated with cachexia/ dehydration (35.2%), cardio-vascular disorders (20.9%), and acute pulmonary diseases such as pneumonia (20.1%);
- of the 15% (one in seven) residents who live until the end stage if dementia is reached, half die from cachexia/dehydration;
- approximately 9% of people with dementia die of an unknown, acute cause.

Therefore, in discussing the goals and plan of care for a resident with advanced dementia, the following issues could be included on the agenda:

- the typical trajectory of dementia;
- the symptoms the resident is currently experiencing that are causing distress, and how they will be managed;
- the likelihood of symptoms that may occur in the future, and how each will be addressed;
- the benefits and burdens of any treatments should be clearly articulated so decisions made about current or future care are based on objective information:
  - urinary incontinence; repeated urinary tract infections;

- gait disturbances that leave the individual at high risk of falls; injuries resulting from falls;
- pneumonia and aspiration pneumonia;
- swallowing problems, dysphagia;
- weight loss due to cachexia;
- dehydration;
- risk of decubitus ulcers;
- anxiety, agitation, aggression, depression, psychotic symptoms;
- loss of ability to communicate verbally, and how symptoms such as pain are recognised and treated;
- the family member's role in care;
- the site of care: a palliative approach to care given in the facility; times when transfer to hospital may be necessary; curative treatments offered in hospitals;
- cardiopulmonary resuscitation (CPR);
- medically provided nutrition and hydration (PEG feeds, subcutaneous hydration);
- blood transfusions;
- antibiotic therapy: in the facility/ in hospital (via intravenous infusion), and whether or not to give antibiotics or/and palliate symptoms with analgesics, antipyretics, sedatives.

The person responsible needs to make decisions based on either the known or probable wishes of the resident; or what is in the 'best interest' of the resident: the relative benefits and burdens of a particular treatment choice in terms of the ability to relieve any suffering and maintain comfort and dignity and the best possible quality of life <sup>49</sup>. Nurses can assist persons responsible by reassuring and encouraging them to think of times when there were conversations about what the resident might have wanted, so that the known or probable wishes of the resident become clearer.

Conflicts are most likely to occur around two main issues- aspiration pneumonia and neurogenic dysphagia <sup>49</sup>. Many clinicians and families find it harder to discontinue a therapy than to withhold it in the first place, so it is particularly important that the person responsible is aware of the burdens and benefits of medical interventions such as PEG feeds. In some instances, it may be easier to institute a trial intervention for a specific time frame eg a trial of oral antibiotics for one week for repeated urinary tract infections, which can be discontinued if unsuccessful <sup>50</sup>. Research in NSW <sup>51</sup> has shown some evidence that residents have an increased survival rate if their plan of care opts for them remaining in an aged care facility rather than transfer to hospital for care, compared to those without a plan of care.

Facility staff not involved in the development of the plan of care during the family conference need to be informed of the outcomes, and be given the opportunity to discuss any decisions they find ethically challenging, so that consensus about the goals of care are reached, and potential for conflict avoided.

## General practitioner contribution to a care plan

A GP may contribute to the care plan of a resident, and be paid under Medicare item no. 731. The recommended interval between reviews is 6 months, but may be 3 monthly. To ensure the GP is remunerated, the following steps need to be undertaken<sup>47, 52</sup>:

1. Invite the GP to contribute to the 'nursing and personal care plan' of the resident;
2. The resident or person responsible need to be informed that the GP will be consulted, and consent recorded;
3. Provide the GP with the resident's notes, to review alongside the GP's own patient notes;
4. The GP will contribute to the care plan by discussing it with facility staff and giving any additions, changes or other recommended management;
5. The fact that the GP contributed to the care plan is documented on the care plan in the facility;
6. The GP is also required to document in the resident's medical records that he or she has contributed to the care plan. The documentation may just be a date, signature, and comment that a contribution to the care plan has been made, but it is also recommended that the GP includes a brief summary of recommendations;
7. Facility staff may write detailed notes into the care plan after verbal discussion with the GP;
8. Once an Item 731 has been claimed by the GP, and it is documented that the resident requires Allied Health or dental services the resident may be eligible for access to up to 5 Allied Health and 3 Dental care services per year.

## SECTION EIGHT: APPENDIX

### Appendix 1

Palliative Care Australia have pamphlets available discussing the use of morphine and similar opioids that can be ordered via the website: <http://www.palliativecare.org.au>. These pamphlets may be useful for the person responsible or other family members who are concerned about the use of strong pain medication.

#### COMMONLY HELD MYTHS AND MISCONCEPTIONS ABOUT MORPHINE AND OTHER OPIOIDS <sup>6, 53</sup>

Family members, and sometimes staff members in a facility, may hold misconceptions about the use of opioids. If that is the case, they will require education and at times reassurance to dispel those misunderstandings.

*Myth: Morphine is only used when death is imminent*

**Fact: Morphine and other opioids can be safely used for the treatment of chronic pain for many months and years before a resident dies.**

*Myth: Morphine and other opioids hasten death, especially in older people*

**Fact: Older people are more sensitive to the effects of opioids, so the dose needs to be calculated carefully (“start low, go slow”), but death will not be hastened. In fact, relieving pain can prolong life.**

*Myth: Morphine and other opioids cause addiction*

**Fact: When Morphine is used to treat pain, addiction (psychological dependence) is extremely rare, and if it occurs it is almost always in a person with a history of drug use.**

*Myth: A person taking opioid medication may stop breathing*

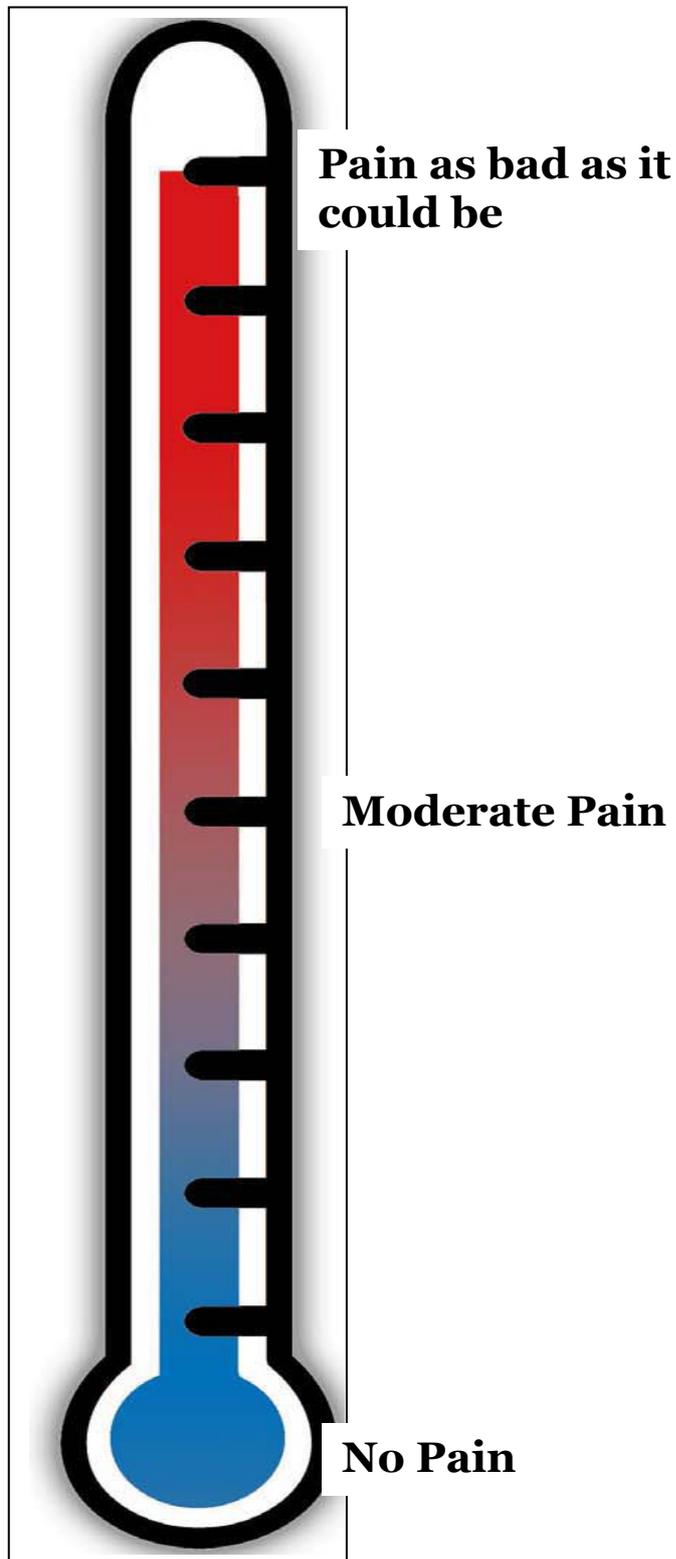
**Fact: It is very rare to have respiratory depression in a person whose dose of opioid has been calculated carefully and is taking the medication regularly. If it does occur, it will normally occur soon after the first dose is given, or after a dose increase. If signs of respiratory depression occur, a reduction in dose or withdrawal of the dose for a short time may be required. If respiratory depression occurs it is most frequently in residents who have never been given opioids before, and is accompanied by other signs of central nervous system depression such as sedation.**

*Myth: A person taking opioids like morphine will become so sedated that they can no longer function*

**Fact: Drowsiness may be a transient side effect of opioids, especially in the first few days of use, but then the resident will usually recover from this. If the resident remains sedated, an evaluation of the dose is required.**

## Appendix 2: pain assessment tools

Figure 1  
**PAIN THERMOMETER<sup>54</sup>**



## SCORING THE PAIN THERMOMETER<sup>54</sup>

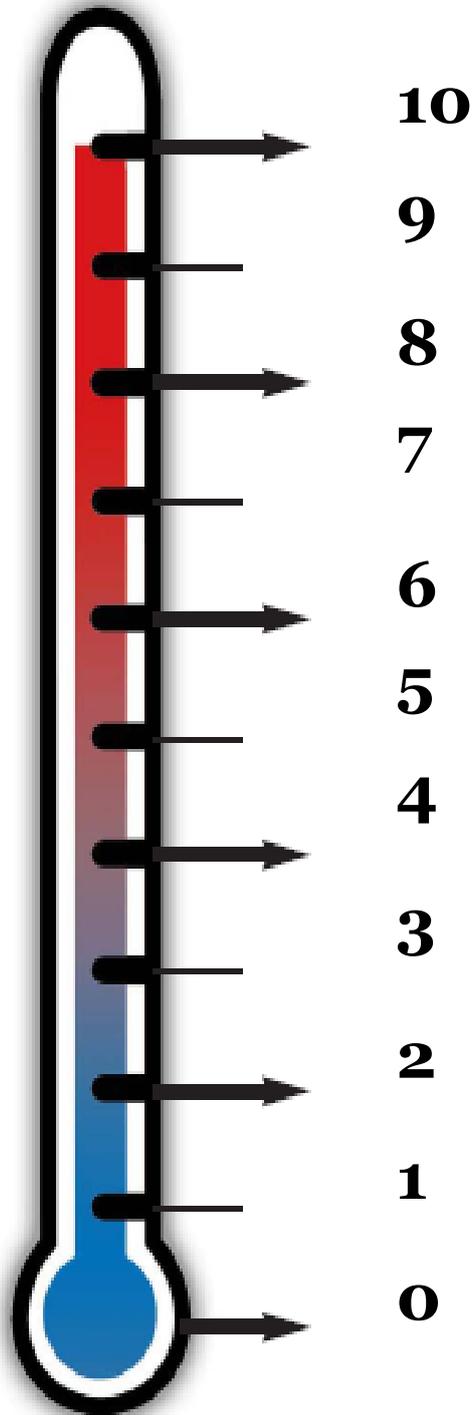


Figure 2

**VERBAL DESCRIPTOR SCALE**

---

**Pain as bad as it could be**

---

**Extreme pain**

---

**Severe pain**

---

**Moderate pain**

---

**Mild pain**

---

**Slight pain**

---

**No Pain**

---

## SCORING THE VERBAL DESCRIPTOR SCALE<sup>55</sup>

<b>10</b>	<b>Pain as bad as it could be</b>
<b>8-9</b>	<b>Extreme pain</b>
<b>7</b>	<b>Severe pain</b>
<b>5</b>	<b>Moderate pain</b>
<b>3</b>	<b>Mild pain</b>
<b>1</b>	<b>Slight pain</b>
<b>0</b>	<b>No Pain</b>

**Figure 3**  
**DOLOPLUS-2 Scale for pain assessment**

<b>DOLOPLUS-2 SCALE</b>		<b>BEHAVIOURAL PAIN ASSESSMENT IN THE ELDERLY</b>						
NAME :		Christian Name :	Unit :		<b>DATES</b>			
Behavioural Records								
<b>SOMATIC REACTIONS</b>								
<b>1• Somatic complaints</b>	• no complaints .....	0	0	0	0			
	• complaints expressed upon inquiry only .....	1	1	1	1			
	• occasional involuntary complaints .....	2	2	2	2			
	• continuous involuntary complaints .....	3	3	3	3			
<b>2• Protective body postures adopted at rest</b>	• no protective body posture .....	0	0	0	0			
	• the patient occasionally avoids certain positions .....	1	1	1	1			
	• protective postures continuously and effectively sought .....	2	2	2	2			
	• protective postures continuously sought, without success .....	3	3	3	3			
<b>3• Protection of sore areas</b>	• no protective action taken .....	0	0	0	0			
	• protective actions attempted without interfering against any investigation or nursing .....	1	1	1	1			
	• protective actions against any investigation or nursing .....	2	2	2	2			
	• protective actions taken at rest, even when not approached .....	3	3	3	3			
<b>4• Expression</b>	• usual expression .....	0	0	0	0			
	• expression showing pain when approached .....	1	1	1	1			
	• expression showing pain even without being approached .....	2	2	2	2			
	• permanent and unusually blank look (voiceless, staring, locking blank) .....	3	3	3	3			
<b>5• Sleep pattern</b>	• normal sleep .....	0	0	0	0			
	• difficult to go to sleep .....	1	1	1	1			
	• frequent waking (restlessness) .....	2	2	2	2			
	• insomnia affecting waking times .....	3	3	3	3			
<b>PSYCHOMOTOR REACTIONS</b>								
<b>6• washing &amp;/or dressing</b>	• usual abilities unaffected .....	0	0	0	0			
	• usual abilities slightly affected (careful but thorough) .....	1	1	1	1			
	• usual abilities highly impaired, washing &/or dressing is laborious and incomplete .....	2	2	2	2			
	• washing &/or dressing rendered impossible as the patient resists any attempt .....	3	3	3	3			
<b>7• Mobility</b>	• usual abilities & activities remain unaffected .....	0	0	0	0			
	• usual activities are reduced (the patient avoids certain movements and reduces his/her walking distance) .....	1	1	1	1			
	• usual activities and abilities reduced (even with help, the patient cuts down on his/her movements) .....	2	2	2	2			
	• any movement is impossible, the patient resists all persuasion .....	3	3	3	3			
<b>PSYCHOSOCIAL REACTIONS</b>								
<b>8• Communication</b>	• unchanged .....	0	0	0	0			
	• heightened (the patient demands attention in an unusual manner) .....	1	1	1	1			
	• lessened (the patient cuts him/herself off) .....	2	2	2	2			
	• absence or refusal of any form of communication .....	3	3	3	3			
<b>9• Social life</b>	• participates normally in every activity (meals, entertainment, therapy workshop) .....	0	0	0	0			
	• participates in activities when asked to do so only .....	1	1	1	1			
	• sometimes refuses to participate in any activity .....	2	2	2	2			
	• refuses to participate in anything .....	3	3	3	3			
<b>10• Problems of behaviour</b>	• normal behaviour .....	0	0	0	0			
	• problems of repetitive reactive behaviour .....	1	1	1	1			
	• problems of permanent reactive behaviour .....	2	2	2	2			
	• permanent behaviour problems (without any external stimulus) .....	3	3	3	3			
<b>COPYRIGHT</b>					<b>SCORE</b>			

## DOLOPLUS-2 SCALE : LEXICON

### **Somatic complaints**

The patients expresses pain by word, gesture, cries, tears or moans.

### **Protective body postures adopted at rest**

Unusual body positions intended to avoid or relieve pain.

### **Protection of sore areas**

The patient protects one or several areas of his/her body by a defensive attitude or gestures.

### **Expression**

The facial expression appears to express pain (grimaces, drawn, atonic) as does the gaze (fixed gaze, empty gaze, absent, tears).

### **Investigation**

Any investigation whatsoever (approach of a caregiver, mobilization, care procedure, etc.).

### **Washing/dressing**

Pain assessment during washing and/or dressing, alone or with assistance.

### **Mobility**

Evaluation of pain in movement: change of position, transfer, walking alone or with assistance.

### **Communication**

Verbal or non-verbal.

### **Social life**

Meals, events, activities, therapeutic workshops, visits, etc.

### **Problems of behaviour**

Aggressiveness, agitation, confusion, indifference, lapsing, regression, asking for euthanasia, etc.

## DOLOPLUS-2 SCALE : INSTRUCTIONS FOR USE

### 1 • Scale use requires learning

As is the case with any new instrument, it is judicious to test it before circulating it. Scale scoring time decreases with experience (at most a few minutes). Where possible, it is of value to appoint a reference person in a given care structure.

### 2 • Pluridisciplinary team scoring

Irrespective of the health-care, social-care or home structure, scoring by several caregivers is preferable (physician, nurse, nursing assistant, etc.). At home, the family and other persons can contribute using a liaison notebook, telephone or even a bedside meeting. The scale should be included in the 'care' or 'liaison notebook' file.

### 3 • Do not score if the item is inappropriate

It is not necessary to have a response for all the items on the scale, particularly given an unknown patient on whom one does not yet have all the data, particularly at psychosocial level. Similarly, in the event of coma, scoring will be mainly based on the somatic items.

### 4 • Compile score kinetics

Re-assessment should be twice daily until the pain is sedated, then at longer intervals, depending on the situation. Compile score kinetics and show the kinetics on the care chart (like temperature or blood pressure). The scale will thus become an essential argument in the management of the symptom and in treatment initiation.

### 5 • Do not compare scores on different patients

Pain is a subjective and personal sensation and emotion. It is therefore of no value to compare scores between patients. Only the time course of the scores in a given patient is of interest.

### 6 • If in doubt, do not hesitate to conduct a test treatment with an appropriate analgesic

It is now accepted that a score greater than or equal to 5/30 is a sign of pain. However, for borderline scores, the patient should be given the benefit of the doubt. If the patient's behavior changes following analgesic administration, pain is indeed involved.

### 7 • The scale scores pain and not depression, dependence or cognitive functions

Numerous instruments are available for each situation. It is of primary importance to understand that the scale is used to detect changes in behavior related to potential pain.

Thus, for items 6 and 7, we are not evaluating dependence or independence but pain.

### 8 • Do not use the DOLOPLUS 2 scale systematically

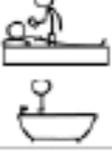
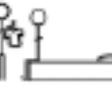
When the elderly patient is communicative and cooperative, it is logical to use the self-assessment instruments. When pain is patent, it is more urgent to relieve it than to assess it ... However, if there is the slightest doubt, hetero-assessment will avoid underestimation.

Figure 4

# NOPPAIN Pain Assessment Tool

<b>NOPPAIN</b> (Non-Communicative Patient's Pain Assessment Instrument) <b>Activity Chart Check List</b>	Name of Evaluator _____ Name of Resident: _____ Date: _____ Time: _____
--	--

**DIRECTIONS:** Nursing assistant should complete at least 5 minutes of daily care activities for the resident while observing for pain behaviors. This form should be completed immediately following care activities

		Did you do this? <small>Check Yes or No</small>	Did you see pain when you did this? <small>Check Yes or No</small>		Did you do this? <small>Check Yes or No</small>	Did you see pain when you did this? <small>Check Yes or No</small>
(a) Put resident in bed <small>OR saw resident lying down</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(f) Fed resident		<input type="checkbox"/> YES <input type="checkbox"/> NO
(b) Turned resident in bed		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(g) Helped resident stand <small>OR saw resident stand</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO
(c) Transferred resident <small>(bed to chair, standing or wheelchair to toilet)</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(h) Helped resident walk <small>OR saw resident walk</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO
(d) Sat resident up <small>(bed or chair) OR saw resident sitting</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	(i) Bathed resident <small>OR gave resident sponge bath</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO
(e) Dressed resident		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>REMEMBER: Make sure to ASK THE PATIENT if he/she is in pain!</b>		

## Pain Response/Responsibility (What did you see and hear?)

<b>Pain Words?</b> <ul style="list-style-type: none"> <li>- "That hurts!"</li> <li>- "Ouch!"</li> <li>- Cursing</li> <li>- "Stop that!"</li> </ul>  <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How intense were the pain words?</p> <p>0 1 2 3 4 5</p> <p>Lowest Possible Intensity      Highest Possible Intensity</p>	<b>Pain Faces?</b> <ul style="list-style-type: none"> <li>- grimaces</li> <li>- furrowed brow</li> <li>- winces</li> </ul>  <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How intense were the pain faces?</p> <p>0 1 2 3 4 5</p> <p>Lowest Possible Intensity      Highest Possible Intensity</p>	<b>Bracing?</b> <ul style="list-style-type: none"> <li>- rigidity</li> <li>- holding</li> <li>- guarding</li> <li>- especially during movement</li> </ul>  <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How intense was the bracing?</p> <p>0 1 2 3 4 5</p> <p>Lowest Possible Intensity      Highest Possible Intensity</p>
<b>Pain Noises?</b> <ul style="list-style-type: none"> <li>- moans</li> <li>- groans</li> <li>- grunts</li> <li>- cries</li> <li>- gasps</li> <li>- sighs</li> </ul>  <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How intense were the pain noises?</p> <p>0 1 2 3 4 5</p> <p>Lowest Possible Intensity      Highest Possible Intensity</p>	<b>Rubbing?</b> <ul style="list-style-type: none"> <li>- massaging affected area</li> </ul>  <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How intense was the rubbing?</p> <p>0 1 2 3 4 5</p> <p>Lowest Possible Intensity      Highest Possible Intensity</p>	<b>Restlessness?</b> <ul style="list-style-type: none"> <li>- frequent shifting</li> <li>- rocking</li> <li>- inability to stay still</li> </ul>  <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How intense was the restlessness?</p> <p>0 1 2 3 4 5</p> <p>Lowest Possible Intensity      Highest Possible Intensity</p>

## Locate Problem Areas

Please "X" the site of any pain  
Please "O" the site of any skin problems

FRONT



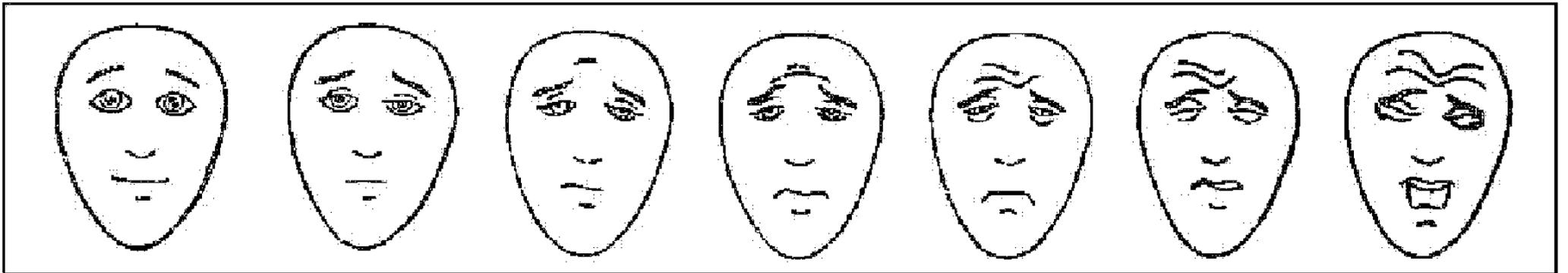
BACK



Snow AL, O'Malley K, Kurik M, Cody M, Bruusa E, Beck C, Ashton C. Developed with support from the U.S. Veterans Affairs Health Services Research & Development Service and the National Institute of Mental Health. For more information, contact Dr. Snow at asnow@bcm.tmc.edu. (This document may be reproduced)

Figure 5

**FACES PAIN SCALE**



## SCORING THE FACES PAIN SCALE <sup>56, 57</sup>

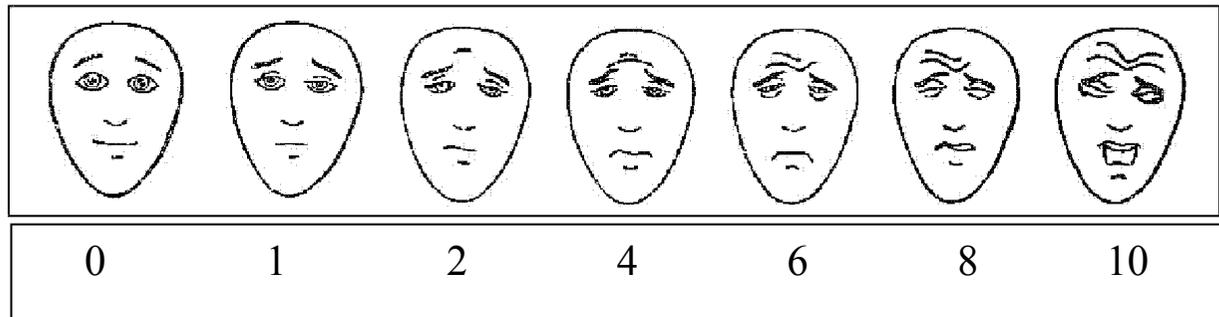


Figure 6

# MOBID Pain Scale

Bettina.Husebo@isf.uib.no;  
 Department of Public Health and Primary Health Care,  
 University of Bergen

MOBILIZATION – OBSERVATION – BEHAVIOUR – INTENSITY – DEMENTIA

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Unit: \_\_\_\_\_

Pay attention to the patient's pain behaviour during morning care. **Observe the patient before you start mobilization.** Explain clearly what is going to happen. Guide the patient carefully through the activities 1–5. Reverse the movement immediately if pain behaviour is perceived.

Rate your observation after each activity:

**I) Tick the boxes for Pain noises, Facial expression and Defence, whenever you observed such pain behaviour.**

**II) Based on pain behaviour, rate the pain intensity with a cross on the lines (0-10).**

## I) Pain Behaviour



**Pain noises:**

- Ouch!
- Groaning
- Gasping
- Screaming



**Facial expression:**

- Grimacing
- Frowning
- Tightening mouth
- Closing eyes



**Defence:**

- Freezing
- Guarding
- Pushing
- Crouching

## II) Pain Intensity

YOU MAY TICK SEVERAL BOXES FOR EACH ACTIVITY

HOW INTENSE DO YOU REGARD THE PAIN TO BE?  
 0 is no pain and 10 is as bad as it possibly could be

1. Guide to open both hands, one hand at a time

0 1 2 3 4 5 6 7 8 9 10

2. Guide to stretch both arms towards head, one arm at a time

0 1 2 3 4 5 6 7 8 9 10

3. Guide to stretch and bend both knees and hips, one leg at a time

0 1 2 3 4 5 6 7 8 9 10

4. Guide to turn in bed to both sides

0 1 2 3 4 5 6 7 8 9 10

5. Guide to sit at the bedside

0 1 2 3 4 5 6 7 8 9 10

Based on your observations, rate the patient's overall pain intensity

0 1 2 3 4 5 6 7 8 9 10

## SECTION NINE: REFERENCES

1. Australian Government Department of Health and Ageing. *Guidelines for a Palliative Approach in Residential Aged Care. Enhanced Version*. Canberra: Australian Government Department of Health and Ageing; 2006. Report No: ISBN: 0 642 82939 X.
2. Australian Nursing & Midwifery Council. National Competency Standards for the Registered Nurse. Available at: <http://www.anmc.org.au>. Accessed 4 February, 2007.
3. NSW Rural Nurses Palliative Care Group. *Practice Guidelines for Palliative Care*. Fourth Edition ed.: NSW Rural Palliative Care Nurses' Group; 1998.
4. Helme RD, Gibson SJ. The epidemiology of pain in elderly people. *Clinics in Geriatric Medicine* 2001;17(3):417-431.
5. Gibson S, Scherer S, Goucke R. *Guidelines for Residential Care. Stage 1: Preliminary field-testing and preparations for implementation. Final Report* Perth: Australian Pain Society and the Australian Pain Relief Association Pain Management; 2004.
6. Australian Government Department of Health and Ageing. *Guidelines for a Palliative Approach in Residential Aged Care*. Canberra: Australian Government Department of Health and Ageing, Rural Health and Palliative Care Branch 2004. Publications approval number 3467.
7. Miller LL, Nelson LL, Mezey M. Comfort and pain relief in dementia: awakening a new beneficence. *Journal of Gerontological Nursing*. Sep 2000;26(9):32-40.
8. Australian Pain Society. Residential Aged Care Pain Management Draft Guidelines. Available at: [www.apsoc.org.au](http://www.apsoc.org.au). Accessed 5th August, 2004.
9. Australian Pain Society. Pain in Residential Aged Care Facilities. Management Strategies. *The Australian Pain Society*. Available at: [www.apsoc.org.au](http://www.apsoc.org.au). Accessed December, 2005.
10. Kumar K, Demeria D. The Role of Opioids in the Treatment of Chronic Nonmalignant Pain in the Elderly. *Annals of Long-Term Care*. 2003;11(3):34-40.
11. Maddocks I, Abbey J, Beck K, et al. *Palliative Care in Nursing Homes. Educational Resource Package*. Adelaide: Flinders University; 2001.
12. Therapeutic Guidelines Limited. *Therapeutic Guidelines Palliative Care version 2*. Melbourne: Therapeutic Guidelines Limited; 2005.
13. Feldt KS. The complexity of managing pain for frail elders. *Journal of the American Geriatrics Society*. May 2004;52(5):840-841.
14. Snow AL. Pain Assessment in Persons with Dementia: An Illustration of Measurement Challenges in a Special Population. *Veterans Affairs Health Services Research and Development*. Available at: [www.measurementexperts.org/news/2005/Winter/commentary\\_pain.asp](http://www.measurementexperts.org/news/2005/Winter/commentary_pain.asp). Accessed 23rd February, 2005.
15. Herr K, Decker S. Assessment of Pain in Older Adults With Severe Cognitive Impairment. *Annals of Long-Term Care*. 2004;12(4):46-52.
16. Feldt KS. Improving assessment and treatment of pain in cognitively impaired nursing home residents. *Annals of Long-Term Care*. Sep 2000;8(9):36-42.
17. Gabre P, Sjoquist K. Experience and assessment of pain in individuals with cognitive impairments. *Special Care in Dentistry*. 2002;22(5):174-180.
18. Fuchs-Lacelle S, Hadjistavropoulos T. Development and preliminary validation of the pain assessment checklist for seniors with limited ability to communicate (PACSLAC). *Pain Management Nursing*. 2004;5(1):37-49.
19. Leonard R, Tinetti M, Allore H, Drickamer MA. Potentially Modifiable Resident Characteristics That Are Associated With Physical or Verbal Aggression Among

- Nursing Home Residents With Dementia. *Archives of Internal Medicine*. 2006;166:1295-1300.
20. Manfredi PL, Breuer B, Meier DE, Libow L. Pain assessment in elderly patients with severe dementia. *Journal of Pain and Symptom Management*. Jan 2003;25(1):48-52.
  21. Gagliese L, Melzack R. Chronic pain in elderly people. *Pain*. 1997;70(1):3-14.
  22. Zwakhalen SM, Hamers JP, Abu-Saad HH, Berger MP. Pain in elderly people with severe dementia: A systematic review of behavioural pain assessment tools. *BMC Geriatrics* 2006;6(3).
  23. Pasero C, McCaffery M. Pain control. No self-report means no pain-intensity rating: assessing pain in patients who cannot provide a report. *American Journal of Nursing* 2005;105(10):50-53.
  24. Abbey J, Piller N, De Bellis A, et al. The Abbey pain scale: a 1-minute numerical indicator for people with end-stage dementia. *International Journal of Palliative Nursing*. 2004;10(1):6.
  25. Warden V, Hurley AC, Volicer L. Development and Psychometric Evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *Journal of the American Medical Directors Association*. Jan-Feb 2003;4(1):9-15.
  26. Auret K, Moffat P, Toye C. Testing pain assessment tools for older people with cognitive impairment: A comparison of three pain assessment tools. *Edith Cowan University*. Available at: <http://www.supportiveandpalliativecare.org.au/research-current.php#26>. Accessed 3 November, 2008.
  27. Snow AL, O'Malley KJ, Cody M, et al. A Conceptual Model of Pain Assessment for Noncommunicative Persons With Dementia. *The Gerontologist*. 2004;44(6):807-817.
  28. American Geriatric Society Panel on Chronic Pain in Older Persons. The Management of Chronic Pain in Older Persons. *Journal of the American Geriatrics Society*. 1998;46(5):635-651.
  29. Wide Bay Division of General Practice Association Inc. Good Practice Procedure. Pain Management for Aged Care Residents. *Wide Bay Division of General Practice Association Inc*. Available at: [www.widebaydgp.org.au/Resources/Pain.GoodPractice.pdf](http://www.widebaydgp.org.au/Resources/Pain.GoodPractice.pdf). Accessed 4th August, 2004.
  30. Weissman DE, Griffie J, Muchka S, Matson S. Featured Innovation Part 1. Improving Pain Management in Long-Term Care Facilities. *Innovations in End-of-Life Care*. 2001;3(1).
  31. Sansone P, Schmitt L. Providing Tender Touch Massage to Elderly Nursing Home Residents: A Demonstration Project. *Geriatric Nursing*. 2000;21(6):303-308.
  32. NSW Health. Hot or Cold Packs Application. In: Quality and Safety Branch, ed. Vol Guideline GL2005\_015. 2005.
  33. Therapeutic Guidelines Limited. *Therapeutic Guidelines Palliative Care*. Version 1 ed. North Melbourne: Therapeutic Guidelines Limited; 2001.
  34. NSW Health. Guide to Handling of Medication in Nursing Homes in NSW. In: Pharmaceutical Services Branch, ed.; 2003.
  35. World Health Organisation. *Cancer Pain relief: a guide to opioid availability*. Geneva: World Health Organisation; 1996.
  36. North West Melbourne Division of General Practice. GP and Residential Aged Care Kit. Clinical Information Sheet. Pain: Assessment and Management 'Round the Clock'. Available at: <http://www.nwmdgp.org.au>.
  37. NSW Health. Paracetamol Use. Policy Directive. In: Quality and Safety Branch, ed.; 2005.
  38. Pain Management Task Group. *Adult Pain Management Guidelines*. Hull: Hull & East Riding Clinical Policy Forum; 2006.

39. Doran J. Transdermal Fentanyl. Available at: <http://www.medicineau.net.au>. Accessed 29 June, 2007.
40. Lynn J, Schuster JL, Kabcenell A. *Improving Care at the End of Life. A Sourcebook for Health Care Managers and Clinicians*. New York: Oxford University Press; 2000.
41. Northeast Health Care Quality Foundation, Curtiss CP. Overview of Best Practice for Pain Management. Available at: <http://www.NHCQF.org>. Accessed 10 July, 2007.
42. Guardianship Tribunal of NSW. Substitute Consent. Available at: [www.gt.nsw.gov.au](http://www.gt.nsw.gov.au). Accessed 24 September 2004.
43. Merl H, Bauer L. *Time to think about Aged Care & Dementia*. Sydney: Central Coast Dementia Advisory Service, North Sydney Central Coast Health, Central Coast Division of General Practice; 2005.
44. Folstein M, Folstein S, McHugh P. Mini mental state: a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*. 1975;12:189-198.
45. Private Guardian Support Unit, Office of the Public Guardian. After The Hearing. An information guide for people appointed as guardians under the NSW Guardianship Act 1987. 1999.
46. Mitchell G. Getting GPs involved in case conferencing and care planning. Paper presented at: National Evaluation Workshop, Local Palliative Care Round Three Grants, 2007; Sydney.
47. North West Melbourne Division of General Practice. Case Conference Items 734, 736, 738. Guide for GPs. Available at: <http://www.nwmdgp.org.au>. Accessed 30 July, 2007.
48. Koopmans RT, van der Sterren KJ, van der Steen JT. The 'natural' endpoint of dementia: death from cachexia or dehydration following palliative care? *International Journal of Geriatric Psychiatry*. 2007;22:350-355.
49. Karlawish JH, Quill T, Meier DE. A Consensus-Based Approach To Providing Palliative Care to Patients Who Lack Decision-Making Capacity. *Annals of Internal Medicine*. 1999;130(10):835-840.
50. Scanlon CJ. Ethical Concerns in End-of-Life Care: When questions about advance directives and the withdrawal of life-sustaining interventions arise, how should decisions be made? *AJN, American Journal of Nursing*. 2003;103(1):48-55.
51. Caplan GA, Meller A, Squires B, Chan S, Willett W. Advance care planning and hospital in the nursing home. *Age & Ageing* 2006;35(6):581-585.
52. North West Melbourne Division of General Practice. Contribution to Care Plan Item 731. Guide for GPs. Available at: <http://www.nwmdgp.org.au>. Accessed 30 July 2007.
53. Hospice of Michigan. Patient/Family Guide. Available at: [www.hom.org](http://www.hom.org). Accessed 28th January, 2005.
54. Herr K, Mobily P. Comparison of selected pain assessment tools for use with the elderly. *Applied Nursing Research*. 1993;6(1):39-46.
55. Jones KR, Vojir CP, Hutt E, Fink R. Determining mild, moderate, and sever pain equivalency across pain-intensity tools in nursing home residents. *Journal of Rehabilitation Research & Development*. 2007;44(2):305-314.
56. Bieri D, Reeve R, Champion G, Addicoal L, Ziegler J. The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: development, initial validation and preliminary investigation for ratio scale properties. *Pain*. 1990;41(2):139-150.
57. Hicks C, von Baeyer C, Spafford P, van Korlaar I, Goodenough B. The Faces Pain Scale - Revised: Toward a common metric in paediatric pain measurement. *Pain*. 2001;93:173-183.

## SECTION TEN: ANNOTATED BIBLIOGRAPHY

The following papers and other resources will be helpful in managing pain and providing a palliative approach to pain for residents with advanced dementia.

1. **Renn CL & Dorsey SG. 2005. The Physiology and Processing of Pain. A Review. AACN Clinical Issues Vol 16 No 6 pp 277-290.**

This paper provides a review of the physiology and processing of pain, and would be useful as a basis for more comprehensive inservice education, in particular for registered nurses.

2. **McCulloch House Combined Medicine Clinic, Southern Health, Victoria. Clinical Protocols and Guidelines, Pain Management. Using a 'Graseby MS26' Syringe Driver for Continuous Subcutaneous Infusions (CSCI):**

[http://www.southernhealth.org.au/mcculloch/health\\_care\\_professionals.htm](http://www.southernhealth.org.au/mcculloch/health_care_professionals.htm)

These guidelines are useful for any facility or individual staff member interested in the Graseby MS26 Syringe Driver. The guidelines contain information relating to preparing, loading and using the syringe driver, with clear photographs and diagrams. Example forms for recording the use of a syringe driver are attached.

3. **North Cumbria Health. Guidelines for subcutaneous siting of the Saf-T Intima device:**

[http://www.northcumbriahealth.nhs.uk/palliatvecare/clinical/syringe/09\\_subcutaneoussiting\\_of\\_the\\_saf\\_t\\_intima.pdf](http://www.northcumbriahealth.nhs.uk/palliatvecare/clinical/syringe/09_subcutaneoussiting_of_the_saf_t_intima.pdf)

These guidelines show via a series of clear photographs the correct procedure for subcutaneous siting of the Saf-T Intima cannula. This paper would be useful for any registered nurse using this type of cannula for the first time.

4. **Clayton JM, Hancock KM, Butow PN, Tattersall MHN & Currow DC 2007. Clinical practice guidelines for communicating prognosis and end of life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. Supplement to: *The Medical Journal Of Australia*. Vol 186 No 12 pp S76-S108.**

These guidelines provide comprehensive information to assist doctors and nurses discuss prognosis and end of life issues with people with eventually terminal conditions, and their caregivers. These guidelines would be very useful to use as part of education sessions relating to communicating difficult issues. Topics included in the guidelines are timing of discussions, preparation, setting, how to discuss prognosis and end-of-life issues, facilitating hope, commencing or changing treatments, discussing future symptom management, discussing the process of death and dying, managing conflict, and discussing medically futile treatments.

The guidelines can be retrieved for use from:

[http://www.mja.com.au/public/issues/186\\_12\\_180607/cla11246\\_fm.pdf](http://www.mja.com.au/public/issues/186_12_180607/cla11246_fm.pdf)

5. **North West Melbourne Division of General Practice. GP and Residential Aged Care Kit. Clinical Information Sheet: Pneumonia; and**
6. **North West Melbourne Division of General Practice. GP and Residential Aged Care Kit. Clinical Information Sheet: Urinary Tract Infection.**

These information sheets were written to assist general practitioners and nurses in residential aged care facilities involved in the care of residents with two common causes of infection in aged care facilities: pneumonia and urinary tract infection. The information contained in each sheet includes background information about the issue, assessment, investigations and management of the infection. Information enabling the clinician provide palliation of symptoms is also included.

The information sheets can be retrieved for use from:

[http://www.nwmdgp.org.au/pages/after\\_hours/GPRAC-CIS-12.html](http://www.nwmdgp.org.au/pages/after_hours/GPRAC-CIS-12.html)  
(pneumonia) and

[http://www.nwmdgp.org.au/pages/after\\_hours/GPRAC-CIS-14.html](http://www.nwmdgp.org.au/pages/after_hours/GPRAC-CIS-14.html)  
(urinary tract infections).