

Pain Management of the Geriatric Patient

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Abstract

Pain is a major public health concern that if left untreated can lead to poor health outcomes. Older adults in particular are at high risk for inadequate treatment of pain. Older adults also often have comorbidities that increase their risk for experiencing pain. The purpose of this paper is to identify barriers to pain management in geriatric patients as well as evidenced-based strategies that registered nurses and advanced practice nurses can use to address those barriers. After reading this paper, nurses should be able to identify (1) appropriate tools for assessing pain in geriatric patients with and without cognitive impairment, (2) cultural considerations that should be taken into account in pain assessments, and (3) appropriate steps and resources for determining correct pain medications for the geriatric patient.

Introduction

Pain has been described as a “subjective perception that results from the transduction, transmission, and modulation of sensory information. This input may be filtered through an individual’s genetic composition, prior learning, history, current psychological status, and sociocultural influences.”¹ As this paper will show, all of these factors are important for the assessment and management of pain. Pain is a major public health concern affecting 100 million American adults, and together with its related lost productivity, pain costs the U.S. 635 billion dollars a year.² Adults with pain report higher health care expenditures than do adults without pain.³ It affects more people than diabetes, cancer, and heart disease combined.^{4,5,6}

Pain can be either nociceptive or neuropathic. Nociceptive pain occurs from damaged or potentially damaged tissues.⁷ Neuropathic pain starts from a primary lesion or dysfunction of the nervous system. Neuropathic pain is common in patients with fibromyalgia, or diabetic neuropathy.⁷ Persistent/chronic pain is pain in one or more anatomic regions that persists or lasts longer than 3 months and is related to mental or physical distress.⁸

Older adults are at a high risk of experiencing persistent pain due to the presence of comorbidities.^{9,10} Among U.S. adults 65 years of age and older, 52.9% (18.7 million) report that pain has bothered them in the past month.¹¹ Among older adults with pain, 74.9% report having it in more than one site.¹¹ Pain in older adults is related to poorer physical function,^{12,13} difficulty sleeping,^{14,15} depressive symptoms,^{13,16} lower physical health scores,⁶ impaired mobility,^{11,17} disability,^{16,18} and poorer quality of life. Yet in spite of its impact on health outcomes, pain remains undermanaged among older adults. Hence, the purpose of this paper is identify barriers to pain management in geriatric patients and identify evidenced-based strategies for nurses and advanced practice nurses (APNs) to address those barriers. The specific objectives for nurses are

to be able to identify (1) appropriate assessments of pain in geriatric patients with and without cognitive impairment, (2) cultural considerations relevant to pain assessments, and (3) appropriate steps and resources for determining correct pain medications for the geriatric patient.

Barriers to Pain Management

Pain Beliefs and Misconceptions

Among older adults, many beliefs and misconceptions about pain serve as barriers to pain management. For example, if older adults think that their pain is a normal part of aging, they may be less likely to seek care for it or take steps to manage it. In addition, some older adults believe that pain medications are appropriate only when their pain is disabling or intolerable. In a study by Sale, Gignac, and Hawker,¹⁹ participants reported taking pain medications only when pain was “very bad”; one said that taking pain medications might only mask mobility problems rather than provide help. Such a belief can keep older adults from taking medication to prevent pain, especially before physically intensive activities, which can lead to difficulty performing physical tasks. Yet another misconception among older adults and even among health care providers is that the sensation of pain can decrease as a person ages.²⁰ The literature on neurological changes in aging adults may be mixed, but it does not support the myth that older adults are less sensitive to persistent pain.²⁰ Finally, there is a misconception and/or fear among older adults that use of pain medications will lead to addiction, which can prohibit some from taking their prescribed pain medications.¹⁹

Difficulties with Pharmacological Pain Management

Another barrier to effective pain management among older adults consists of complications related to pharmacological therapy. Older adults often experience polypharmacy—they must take multiple medications.²⁰ In one study with 786 older adults, 39%

were experiencing polypharmacy, and 20% experienced dangerous drug interactions.²¹ Polypharmacy in older adults complicates pharmacological pain management and presents a higher risk of such dangerous interactions.²⁰ In addition, taking extra medications (e.g., pain medications) can become overwhelming. Sale et al.¹⁹ reported that some older adults with osteoarthritis were taking more than 20 pills per day and skipped pain medications in order to have one less pill to worry about.

Due to physiological changes associated with aging, older adults may have difficulty metabolizing pain medications or may be at high risk for their side effects. For example, the aging process can impair gastrointestinal (GI) motility and blood flow, which can affect the absorption of certain drugs.²² Hepatic blood flow also decreases as a person ages, which may also affect the metabolism of medications.²² Non-steroidal anti-inflammatory medications (NSAIDs) should be used with caution in high-risk groups including those who are 75 years of age and older with a history of GI bleeding and those who are taking oral corticosteroids, anticoagulants, or proton pump inhibitors.²³ Although pharmacological therapy can be effective for managing older adults' pain, it should be used with caution. The physiological changes and risks for side effects from pain medications can make pharmacological therapy for pain in older adults unpredictable and at times difficult.

Pain in Older Adults with Cognitive Impairment

Although older adults with a diagnosis of dementia are 23% more likely to report pain than older adults without dementia,¹¹ there are many barriers to managing pain in older adults with dementia or cognitive impairment.²⁴ In a literature review that examined barriers to pain assessment and treatment among older adults with dementia, McAuliffe, Nay, O'Donnell, and Fetherstonhaugh²⁴ reported that symptoms related to pain in patients with dementia are often

missed or misinterpreted. Researchers have reported that older adults with severe dementia show more behavioral and psychiatric symptoms related to their pain than do older adults with mild or early stage dementia.²⁵ But these behavioral and psychiatric symptoms are often confused with dementia-related behaviors and not identified as pain-related: Because individuals with dementia may have difficulty understanding the meaning of the sensation of pain, it can be expressed as behavioral and psychiatric symptoms.²⁵

In a study of 121 nursing homes, Allcock, McGarry, and Elkan²⁶ found that a potential barrier to pain management was the lack of policies regarding assessment tools and residents' pain management. Fifty-nine percent ($n = 47$) of the nursing homes did not have written policies for pain assessment and treatment. Lack of adequate and appropriate use of assessment tools is an obstacle to achieving adequate pain management in older adults with dementia.²² Research is being conducted so that we may better understand how to assess and manage pain in geriatric patients with cognitive impairment and/or dementia. Below is a case study of an older adult with cognitive impairment and pain.

Case Study 1: Ms. Jones is a 73-year-old women with severe dementia. She was recently admitted to a long-term care facility. Ms. Jones has a history of osteoarthritis to both knees and diabetic neuropathy to both of her feet. The first week Ms. Jones was in the nursing home she was actively participating in physical therapy and was very calm in her interactions with staff. During Ms. Jones' second week in the facility she is agitated and very guarded when staff attempt to help her out of bed. She yells out at night and has a loss of appetite. The health care providers caring for Ms. Jones in the facility believe her "honeymoon phase" is over and now they have a "difficult" resident on their hands.

Ms. Jones' osteoarthritis and diabetic neuropathy are conditions that often present with persistent pain. Ms. Jones had an active first week in the new facility, but she may have had a flare-up of either or both of these conditions in the second week. She was displaying behavioral symptoms that might have been related to her cognitive impairment, but given that her behavior manifested itself much differently than it did in the first week, it should alert health care providers that she might be in pain. Her increased agitation, guardedness, and change in appetite could all be symptoms of her experiencing unrelieved pain.

Older Minorities and Pain Management

Older racial/ethnic minorities may experience higher rates of pain and more pain-related disability than non-Hispanic White groups do,^{16,27,28} and they may experience greater barriers to adequate, effective pain management.^{29,30} Among older racial/ethnic minority groups in the U.S., language barriers can lead to difficulty in assessing pain.¹⁰ Researchers have also documented that racial/ethnic minorities are less likely to receive opioid medications for their pain and that their pain is often underestimated by health care providers.^{28,31} It is important that health care providers take into account cultural beliefs and practices when assessing pain and treating it. Below is an example case study of an African American women with pain who might need a culturally responsive pain assessment.

Case Study 2: Ms. Johnson is a 78-year-old African American woman who suffers from chronic lower back pain from a previous injury and osteoarthritis in her right knee. She is a first time patient seeing an advanced practice nurse for a yearly physical exam. Ms. Johnson's daughter attends the appointment with her and explains to the advanced practice nurse that her mother used to take walks all the time and go down to the senior center for recreational activities and now she hardly does that anymore. When the provider asked Ms. Johnson if she was experiencing pain Ms. Johnson said "it's nothing the good Lord can't handle and I don't want to be doped up on a bunch of pills. Besides I don't expect to feel any different with these old bones." Ms. Johnson's daughter explains that she won't ever complain about her pain or health in general and it scares her because she does not know what is going on with her mother most of the time.

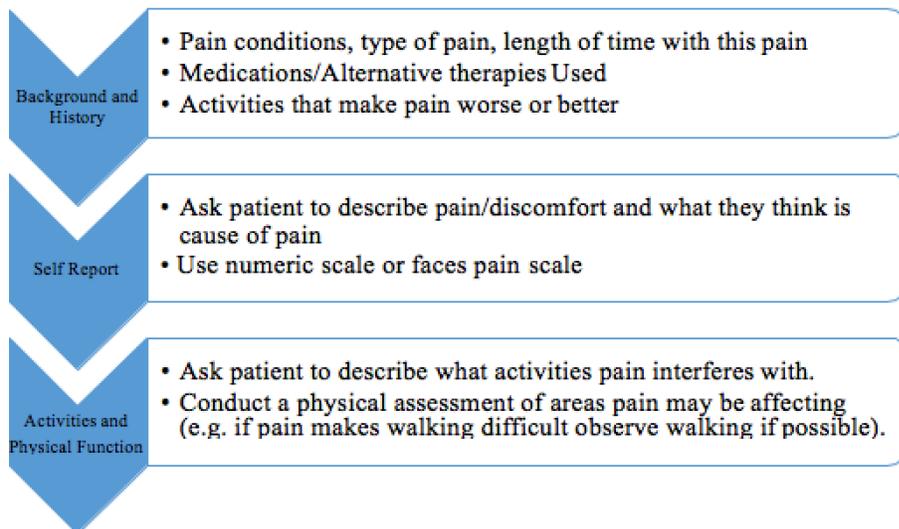
Like any patient, Ms. Johnson cannot be stereotyped on the basis of her race/ethnicity or any other characteristic. However, in listening to Ms. Johnson, it is clear that cultural beliefs and practices may suggest a need for culturally responsive approaches to assessing her pain.³² For example, Ms. Johnson acknowledges that "the good Lord" can handle her pain. Her spiritual beliefs may be guiding her perceptions of pain or her beliefs about treatment. In addition, her daughter states that her mother does not complain about her pain even though she is unable to do the things she used to do. If Ms. Johnson is experiencing debilitating pain, she may be hesitant to report it, and she may not want to feel that she is a burden to her daughter.³² Ms. Johnson also states that she does not want to be "doped up on pills." She may have personal experiences of pain medications; certainly she seems to have beliefs about them.

Nursing Strategies to Improve Pain Management among Geriatric Patients

Pain Assessment

To improve pain management among geriatric patients, nurses must perform appropriate assessments. Nurses caring for older adults must be educated about pain in geriatric patients and in appropriate pain assessment steps.^{25,33} For successful pain management, a thorough assessment should include patient history, pain description, and a physical examination.³⁴ The pain assessment should begin with the patient's self-report of pain using his/her own terminology, followed by a health history that includes current medications and alternative therapies.³³ Next, the assessment should include a baseline assessment of physical function to recognize current state and any further decline.³³ Finally, the assessment should include a measure of pain intensity using a pain rating scale such as the numeric rating scale or the Faces Pain Scale.³³ Figure 1 provides an example of a pain assessment in the geriatric patient.

Figure 1: Assessment of Pain in Geriatric Patient without Cognitive Impairment



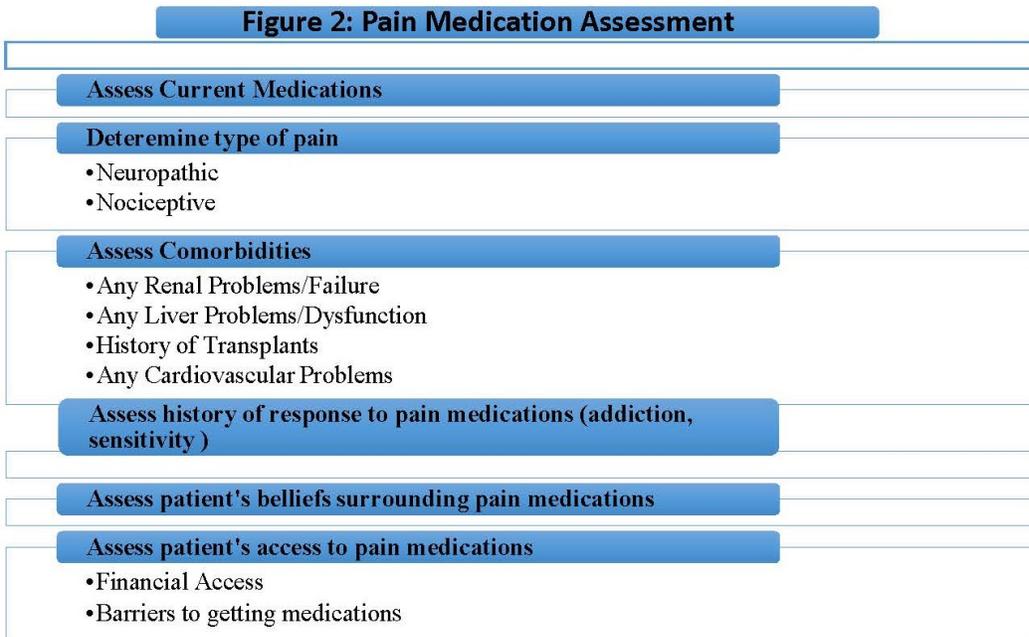
Addressing Pain Beliefs and Misconceptions

It is essential that nurses educate their geriatric patients by addressing misconceptions and beliefs that may³⁷ present as barriers to pain management. Nurses should emphasize to patients and their families that pain is not a normal part of aging. Older adults should be informed that if pain is severe enough to impact physical function, it is not normal.²⁰ In addition, nurses can explain that pain sensation does not necessarily decrease with age and that the use of proactive pain management can help avoid strain on muscles and added difficulty with physical function, as well as reduce the risk of intolerable pain.^{20,34} Nurses should also listen to older adults' concerns about addiction and take a full health history to identify any increased risk of psychological dependence.^{35,36} Geriatric patients who demonstrate a high risk for psychological dependence should be carefully evaluated, and a pain management plan that takes into account the risk for dependence should be in place.³⁶ Geriatric patients who do not demonstrate risk of psychological dependence should be educated about signs of addiction, including feeling the need to take medications when not in pain and experiencing mood changes. The geriatric patient should be encouraged to follow up with health care providers frequently during the duration of any pain medication regimen.

Addressing Pharmacological Pain Management Barriers

Nurses caring for geriatric patients should be familiar with the current pharmacological recommendations of the American Geriatrics Association's BEERS criteria for medications that are not appropriate or that should be used with caution in older adults.²³ Figure 2 presents an example of pain medication assessment in older adults that can be used as a guide to determine

appropriate medications for pain in the geriatric patient.



The assessment above can help determine the best pain medications for older adults. Knowledge of current medications can help reduce the risk of drug interactions. Assessing for comorbidities will alert the nurse about any potential conditions that may be contraindicated with certain pain medications.²³ A patient with liver dysfunction, for example, may not be a good candidate for acetaminophen. Knowing the type of pain can determine what classes of medications should be considered. It is well documented that gabapentin is an effective medication for neuropathic pain³⁷; however, it should be used with extreme caution or avoided in older adults with reduced kidney function.²³ Serotonin and noradrenaline reuptake inhibitors (SNRIs) have also been shown to be effective in addressing neuropathic pain³⁷; however, these too should be used with extreme caution in older adults, in whom they may cause inappropriate antidiuretic secretion or hyponatremia.²³ For nociceptive pain, acetaminophen is recommended if the patient does not have liver problems or any other contraindications.³⁸ If acetaminophen is not

effective, tramadol or short-term use of non-steroidal anti-inflammatory drugs (NSAIDs) may be the next step.³⁸ Tramadol should be used with caution among older adults with low seizure thresholds.²³

Opioids are generally considered a last resort when choosing pain medications for the geriatric patient. Opioids have shown no long-term benefit for persistent pain, and in older adults they can have many side effects (e.g., increased confusion, constipation, CNS adverse effects).^{38,39} Pentazocine is one opioid in particular that may cause confusion and hallucinations more than other opioids.²³ Opioids should also be avoided in geriatric patients with a history of falls or fractures.²³ Despite such complications for the use of opioids in geriatric patients, however, studies have supported opioids' short-term benefits for musculoskeletal pain and some neuropathic conditions.³⁹ If opioids are used, the geriatric patient should be closely monitored, and appropriate laxative therapy should be started in order to address constipation.³⁹ Laxative therapy can include increased fiber and fluids, as well as a laxative or stool softener. In addition, it is recommended that if opioids are used, the use of other CNS-active medications should be decreased.²³ Assessment of a person's history of pain medication can alert the nurse to potential significant side effects or sensitivities.

Older adults with a history of addiction may fear taking pain medications and may require additional resources (e.g., extra monitoring, counseling, etc.). The CDC's (2016) recommendations on opioids are a good resource if a patient has a history of addiction.⁴⁰ Next, the patient's beliefs about pain medications should be assessed. The patient should be asked his/her thoughts on taking pain medications and whether he/she may have any concerns about taking pain medications. The nurse can provide education on any misconceptions about a medication or work with the patient's belief system when prescribing medications. If taking pain

medications is against the patient's beliefs, the nurse should attempt to find non-pharmacological alternatives. The nurse should learn of alternative therapies such as herbs and notify the patient of any potential interactions.

It is important to assess for the geriatric patient's access to medications. Will insurance cover the medications prescribed? Can the patient obtain refills? Many community-dwelling older adults may have difficulty in getting transportation to their health care providers for reassessment to obtain refills. This too can be considered before prescribing medications. A social worker should be consulted if the geriatric patient has barriers to medication access. The health care provider and/or interdisciplinary team should be alerted to the patient's difficulty in accessing prescriptions. Until access is obtained, such patients can utilize nonpharmacological strategies and over-the-counter medications if they are not contraindicated.

Nonpharmacological strategies can supplement pain medications. Nurses can recommend nonpharmacological strategies to community-dwelling older adults and/or older adults in long-term care or assisted living facilities. Older adults can participate in these activities at local community centers if they can access them. Home care nurses can work with patients to use some of these strategies (e.g., heat therapy and exercise) if not contraindicated in the home. Families in the home can learn about such strategies as well and help the patient if desired. In addition, nurses can help patients get physical therapy and/or occupational therapy. Some patients may also benefit from seeing a psychologist or psychiatrist for cognitive behavioral therapy, which has shown positive outcomes in patients with persistent pain. Participation in group activities or gardening can be nonpharmacological exercise options for both community-dwelling and geriatric patients in nursing homes.⁴¹ Table 1 lists nonpharmacological strategies and the types of pain that they have been used to address in research studies.

Table 1: Nonpharmacological Pain Management Methods

Nonpharmacological Treatment	Type/Types of Pain Treated
Tai Chi and yoga	Osteoarthritis related pain ⁴²
Physical therapy	Persistent pain and low back pain ^{43,44}
General exercise	Back pain ⁴⁵⁻⁴⁷
Heat therapy	Back pain ⁴⁸
Cognitive behavioral therapy	Back pain ^{46,49}
Assistive devices	May reduce pain intensity ³⁹
Transcutaneous/percutaneous electrical nerve stimulation	Osteoarthritic knee pain ⁵⁰
Acupuncture (deep needling)	Persistent low back pain ^{51,52}

An interdisciplinary approach to pain management can inform decisions about the most appropriate approaches for pain management.⁵³ For example, an interdisciplinary team that includes a pain specialist, primary care provider, nurse, physical therapist, and psychiatrist could develop a tailored pain management plan with appropriate medications and nonpharmacological pain management strategies. In addition, nonpharmacological strategies can be helpful when coupled with pharmacological pain management in older adults.^{39,48,54,55} Nurses can serve as leaders of interdisciplinary pain management teams. Nurses often have the most time with the patient and can do thorough assessments. They have a clear picture of how the patient's pain is being managed on the patient's current treatment plan. Hence, nurses can establish communication with pain specialists, physical therapists, and primary care providers to ensure that all are on the same page. Nurses can advocate for older adults with pain when their current pain medications and/or treatment regimens are not effective.

Nursing Strategies for Pain in Older Adults with Cognitive Impairments

In Case Study 1 above, Ms. Jones displayed different behavioral symptoms in her second week in the facility. It is essential that a baseline assessment be done for older adults with

cognitive impairment and/or dementia in order to recognize and evaluate behavioral changes.

Ms. Jones had a history of osteoarthritis and diabetic neuropathy that could have been causing her pain. Pain should not be dismissed as the causative factor for her behavioral changes.

It is important that nurses caring for geriatric patients with cognitive impairments and/or dementia are able to recognize symptoms of pain and advocate for appropriate pain management. Nurses should conduct accurate assessments of pain in geriatric patients with dementia and recognize nonverbal and verbal expressions of pain in this group.²⁵ Current recommendations for pain assessment in patients with advanced dementia include the following:

- Search for the cause of pain
- Self-report
- Behavioral observation
- Proxy report
- Response to analgesic trials⁵⁵

The search for the cause of pain is an essential first step in the assessment. An older adult may have a pressure injury or other conditions that may be causing pain. Next, self-report is a reliable means to assess the subjective experience of pain; however, this may not be possible in older adults with advanced dementia. In the case of a patient like Ms. Jones, who is a patient with advanced dementia, behavioral observations should follow.⁵⁶ Behavioral symptoms that one might observe include increased agitation, increased confusion, sleep disturbances, yelling or moaning, or socially disruptive behaviors.⁵⁷ The patient's gait, eating habits, and range of motion can also be assessed. A decline in any of these may indicate pain. In addition, an assessment of vital signs (e.g., increased blood pressure or respiratory rate) may be indicative of acute pain, though it may not be useful for detecting persistent pain.⁵⁸ A documented baseline assessment of

Ms. Jones could be used for comparison with her current symptoms. The next step of a pain assessment in patients with advanced dementia is to consult with a proxy/family member about types of pain, behavioral symptoms, history of pain management, and responses to pain before dementia. Among geriatric patients in long-term care facilities, a nursing assistant could also be asked about behaviors and any signs that pain might be present.⁵⁹ Finally, the patient with advanced dementia should be evaluated for responses to position changes, removal of potential pain stimuli, and response to analgesic trials. In the case of Ms. Jones, if it was suspected that she was in pain, repositioning her and treating her pain should be attempted. Her symptoms should then be reevaluated. The prescribing health care provider can determine the medications that are best for her. In addition, it would be important to monitor her behaviors for any side effects of prescribed analgesics.

The use of evidenced-based validated tools can also lead to a more accurate assessment of pain in older adults with dementia and/or cognitive impairments.⁶⁰ Table 2 presents a list of pain assessment tools for geriatric patients with dementia/cognitive impairments. Although

Table 2
Tools Used to Measure Pain among Geriatric Patients with Dementia

Pain Assessment Tool	Behaviors/Observations Used to Measure Pain
Pain Assessment in Advanced Dementia (PAINAD) Scale ⁶²	Facial expressions, verbalizations and body movements
Noncommunicative Patients' Pain Assessment Instrument (NOPPAIN) ⁶³	At rest responses, pain responses
Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) ⁶⁴	Facial expressions, activity/body movements, mood, and other
Pain Assessment for the Dementing Elderly Scale (PADE) ⁶⁵	Facial expressions, functional tasks
Checklist of Nonverbal Pain Indicators (CNPI) ⁶⁶	Non-verbal vocalizations, facial grimaces, restlessness, verbal complaints

researchers have done literature reviews and identified reliable assessment tools,⁶¹ there is currently no standardized tool for assessing behavioral pain indicators in nonverbal geriatric patients for broad use in clinical practice.⁶⁷

Nursing Strategies for Older Minorities in Pain

In the case of Ms. Johnson in Case Study 2, the APN should begin the assessment by asking Ms. Johnson if she is in pain. The APN may want to ask Ms. Johnson's daughter to step out, depending on Ms. Johnson's preference, or include her in the assessment. It is important for Ms. Johnson to feel that she can communicate openly and that what she has to say is valued. If Ms. Johnson appears reluctant to report pain, the APN can let her know that it is okay to report pain, and that this is not considered to be complaining.³² The APN should then ask Ms. Johnson to describe her beliefs and perceptions about pain. Ms. Johnson should be allowed to describe her pain in her own words.³² The APN should ask Ms. Johnson what her pain goals might be. She can set numeric goals, or her goals might be to be able to perform certain activities. Ms. Johnson should be included in her pain's management. Her religious beliefs should be respected and her pain management can reflect her beliefs. For example, Ms. Johnson might state that church is a priority and that physical therapy cannot interfere with church services. Such preferences must be taken into consideration and respected.³² Finally, a follow-up appointment should be scheduled to reassess Ms. Johnson's pain.

To address barriers to pain management in older racial/ethnic minority groups, nurses should use culturally appropriate instruments and culturally sensitive assessments to evaluate pain. For racial/ethnic minority patients with pain, it is important to use tools that have been validated in respective populations. Issues can arise if a tool is not validated or translated accurately.⁶⁴ If a tool's translation is inaccurate, it may be difficult for the patient to understand,

and the patient may find it hard to express his/her pain intensity.⁶⁸ To simply use a pain assessment tool that is written in English by having someone read it to the patient in the patient's own language can make the tool ineffective. Tools must be tested for proper translation so that patients cannot misunderstand the questions being asked. Furthermore, when patients are asked about their pain, certified translators should be present. It is essential that nurses use certified translators who are approved for their respective health care settings. Patients whose primary language is not English may use different terminology for pain. Nurses who ask about pain might need to use other terms as well, such as *discomfort* or *hurting*. Nurses can also ask non-English-speaking geriatric patients if there is anything they can no longer do because of discomfort in the body. In addition, APNs should ensure that patients whose primary language is not English have a full understanding of any medications prescribed and how to use them. Directions for pain medications should be given to patients in their primary languages.

Nurses should never make generalizations about racial/ethnic groups but should use culturally appropriate assessment techniques.⁶⁸ For example, Booker, Pasero, and Herr³² suggest steps to assessing pain in older African Americans, which include the following: inquiring about pain, measuring pain based on the patient's preferred way of describing it, and appropriate documentation of the assessment. Finally, geriatric patients' cultural beliefs should be considered in developing pain management plans. For example, among some Native Americans, traditional healers may be crucial in the healing process for pain⁶⁹; this might be a strategy to be included in a pain treatment plan if the patient should desire it.

Nursing Strategies for Pain Assessment and Management in Various Settings

The pain assessment techniques described above can be utilized in various settings, such as acute care clinics, residential homes, and long-term care facilities, but they may need to be

adapted to the setting itself. The assessment of pain in the nursing home should begin upon admission. A complete history and physical examination should be completed, including any pertinent diagnosis or past history of pain. It is important to get a good baseline of the patient's cognition and functional status. The goal of the assessment is to find out whether the geriatric patient has pain, determine the pain's cause and severity, and decide the best mode of treatment.³⁴ A continual assessment of pain should occur for as long as the patient remains in the facility. Although the medical data sheets in many long-term care facilities include questions on the intensity of pain, it is important to expand on this and ask the patient and/or family members to describe the pain and any related symptoms in their own words.³⁴ The assessment should start with self-report. In determining the plan of care for pain, an interdisciplinary team can be formed that would include the primary care provider, nurse, social services, and rehabilitation services. Team members should respectively conduct assessments of the patient and how their services can contribute to the patient's overall pain goal.

When assessed for pain in the clinic, the geriatric patient may not be coming in solely for that condition, so a follow-up assessment for persistent pain should be done at each visit. The APN should also ask about any new pain that has occurred since the last visit and about its characteristics. Self-report should again be the first step in assessing the older adult. It is essential for APNs to provide adequate time for patients to communicate their pain experiences and describe them in their own words. Geriatric patients often feel rushed or experience difficulty in communicating during visits to their health care providers, which can serve as a barrier to adequate pain assessment and management.³⁹ The APN can also ask the geriatric patient what their own goals would be regarding their pain and whether they have any preferences regarding pain management. Next, for geriatric patients without cognitive

impairment, pain scales can be used to assess pain. One instrument designed specifically for geriatric patients, the Functional Pain Scale,⁶⁷ can be used quickly; it includes both objective and subjective measures. The tools listed in Table 2 can be used for the geriatric patient with cognitive impairment. When deciding on pain medications, the APN should use the steps in Figure 2. Referrals to physical therapy, a pain management specialist, and/or a psychiatrist/psychologist may be discussed and completed during visits as well.

Nurses and APNs visiting geriatric patients in their private homes should also follow the steps in Figure 1 for pain assessment. In addition, scales appropriate for the patient's cognitive level can be used to assess pain.³⁴ When assessing physical function, nurses can observe patients doing certain activities in the home (e.g., going up stairs) and determine whether physical therapy or occupational therapy might be needed within the home. Geriatric patients in the home do not have constant monitoring as do patients in a facility, so it is essential that nurses visiting homes conduct thorough assessments of pain. Family members or others living in the home may be included in the assessment if needed or preferred by the patient. Caregivers in the home may be able to provide information on patients with cognitive decline and their normal activities and/or behaviors. It is important that geriatric patients be educated about notifying their primary care provider if pain suddenly worsens or becomes unbearable. It is also important that geriatric patients in the home be encouraged to report any side effects from pain medications and/or if pain medications are not effective. Geriatric patients and their families may be unsure about whom to notify about pain medications and/or pain symptoms, so the nurse can clarify who the appropriate provider would be. The nurse visiting the home can educate caregivers on assessing behavioral symptoms daily in the cognitively impaired geriatric patient to recognize pain. Nurses

should also conduct a thorough assessment of the patients' medications, specifically asking about any herbs or alternative medications being used for pain (see Figure 2).

Conclusion

Pain in older adults is often complex; if undermanaged, it can lead to poor health outcomes and poorer quality of life. Specific barriers that contribute to inadequate pain management in geriatric patients include older adults' misconceptions about pain, pharmacological side effects and complications, presence of dementia/cognitive decline, and a lack of culturally appropriate pain assessment techniques for racial/ethnic minority elders. Nurses serve at the forefront of pain management and can address each of these barriers. Through appropriate assessments, nurses can capture the pain experience of the geriatric patient. Nurses can then strategize with members of the health care team, caregivers, and/or family members to develop effective pain management plans. In addition, nurses can ensure that pain management among geriatric patients is guided by evidenced-based practices and is focused on meeting the unique needs of each geriatric patient.

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