

Talking to older people in care homes: Perceptions of their pain and their preferred management strategies. Results of a pilot study

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Abstract: This paper describes a qualitative study that was conducted within the care home setting to determine the pain experiences of residents, their preferred strategies and the staff attitudes and understanding about pain. An exploratory cross sectional study within six care homes within one district was conducted using several methods of data collection. The residents and staff were interviewed and a questionnaire given to a random sample of staff. Several key themes were identified by residents including a reluctance to report pain, acceptance that pain was normal and low expectations of help from medical interventions, fear of chemical or pharmacological interventions, age related perceptions of pain and lack of awareness of potential pain relieving strategies. Staff interviews highlighted that they wanted to know if the residents were in pain, wanting to do more and an interest in using complementary therapies. Recommendations are made for further research in this area.

Keywords: Older persons, pain, staff, disability, nursing home, United Kingdom

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INTRODUCTION

The management of pain has evolved and improved over the last few decades and a major contributing factor to this has been the introduction of the Gate Control Theory (1). This theory advocates the appreciation of many factors that contribute to the individuality of the pain experience, and promotes multidimensional management as opposed to single specialist care (2). Developments in pain management since 1965 include; the introduction of standard definitions of pain, pain services and a widespread recognition that pain management requires a multidimensional perspective and therefore, a multidisciplinary approach.

In spite of this, there are groups within society, who still do not appear to be adequately catered for, including people with learning disabilities or ethnic minorities. Such groups are not provided with services

designed to address their specific needs. A further group in this category are older people, although they are receiving more interest in recent years, there is still less research around their needs than the general adult population.

For example a recent study investigated the educational requirements of nurses who care for the most vulnerable in this group living in care homes (3) and another study by Closs (4) highlighted the concerns regarding appropriate measurement of pain in the older population. Both studies recommended that further study was needed. The purpose of the current study was to investigate the residents and staff perspectives regarding the prevalence of pain within the care home setting and to identify the views of older people in terms of their preferred pain management strategies.

Background

Historically, pain has been viewed as a natural part of ageing and therefore, considered to be something that the person must learn to live with (5). However, it has been suggested that 80% of those over the age of sixty-five suffer at least one chronic illness (6) and that 50% of cancers occur in the over sixty-five age group. This was reinforced in a recent study by Blomqvist (7), who highlighted that in a group of 150 older people, there were a range of potentially painful conditions including falls, leg ulcers, degenerative joints and cancer, and that many of these were well known and visible. However, Blomqvist (7) noted that the management of pain in this group was very poor.

Some have suggested that there could be age related changes, occurring in the older age group, which result in complex alterations in the processing of pain through the nervous system. Examples of this can be seen in practice as in the work of Morrison and Siu (8), who reported patients experience of silent myocardial infarctions, or abdominal catastrophes, or the differences in response to fractures in dementia patients versus non dementia patients (8).

There have also been major developments in terms of pain assessment, for example the introduction of the McGill Pain Questionnaire (9) as a multidimensional pain tool. This has been translated into eighteen languages and used across the age spectrum. But assessment of pain in the older age group still remains poor, and there have been many reasons cited as to why this is so (4). Where assessment scales have been used, some success has been reported, with the visual analogue scale and the faces scale (10). Although Closs et al (10) highlight the difficulties encountered within the care home population when using these scales, in terms of visual, hearing and communication problems.

Some researchers have attempted recently to address these issues and to develop scales, that specifically rely upon the behaviours of the patients, instead of verbal reports, and the investigators suggest some success with their measures (11-13).

A further issue highlighted in the literature, suggests that older people do not wish to bother staff or complain, and they believe that the doctors and nurses are the experts and will “know” when they are in pain (14). However, the United Kingdom (UK) National Service Framework (15) advocates that older people should be more involved in making decisions involving their own treatment, and as such staff should include them in the assessment process, and enable them to make informed decisions regarding treatment. Furthermore, the skills of the health care professionals can be

questioned since pain is an intrinsic experience that is not readily obvious to the observer, and subsequently requires a level of expertise to identify. According to Wittgenstein (16) we can only know, when we have pain and assume when others have pain based upon our observations. Furthermore, the assumption that doctors and nurses “know” when their patients are experiencing pain does rely upon a level of understanding and knowledge on their part which is not always the case. As suggested by Cowan et al (17) such a level of understanding does not exist, and consequently patients receive poor pain management. Historically, education about pain for both doctors and nurses has been poor and although it is improving, the issue of Opiophobia (18) stills remains and there are concerns regarding addiction, tolerance and dependence which prevent appropriate administration of many analgesic drugs, including Opioids. Furthermore, fears of adverse side effects exist for both staff and the older people themselves (19).

It is evident that there are a number of issues, highlighted within the literature, that appear to explain, why there is poor pain management in older people, and the topic has received little attention within the research field to date (20). Such issues are related to the older people themselves, and those who care for them; however, there are many concepts that require further investigation. Therefore, it would seem appropriate to explore the issue of pain in older people in more detail, with a particular emphasis upon the most vulnerable in this group, those living in care homes. This group are relatively powerless, and rely upon the staff for their pain management. It would be interesting therefore to know if the management offered, is that which they themselves would prefer.

Aim of the study

Whilst others have investigated the educational requirements of staff and the assessment of pain in care homes, this study was the first in the UK to examine the preferences of the residents themselves. Therefore the study has three aims:

- To determine the incidence and nature of pain as it exists within a small sample of care homes in the north of England.
- To determine how the staff perceive residents pain and identify their preferred pain management strategies.
- To determine the preferred pain management strategies of the residents themselves.

An exploratory cross sectional study within six care homes within one district was conducted using several methods of data collection. The residents and staff were interviewed and a questionnaire was given to a random sample of staff. Data on demographic details were collected from the residents themselves. This paper will present the findings of the qualitative data collection obtained by interviewing the residents.

METHODS

The area selected for the study consists of a population of 374,200 of which 63,825 are over the age of sixty-five. Within this area there are 105 care homes. Six care homes were randomly selected from the pool of homes and were representative of nursing, residential and mixed groups. Residents were selected by adhering to inclusion criteria, which included informed

consent and completion of the mini-mental state questionnaire (MMSE) (21) For the purpose of the study, only those residents who scored >23 were included as they were considered capable of answering extensive questions regarding pain and its management. All members of staff, both qualified and unqualified were invited to take part in a discussion group, and a random sample of staff were invited to complete a pain knowledge questionnaire.

Measures

The residents were interviewed using a semi-structured format, which consisted of asking questions regarding their past and current medical history, and pain history followed by questions about pain and any pain producing problems such as arthritis. Further questions were related to ways of coping with pain, and pharmacological interventions. A questionnaire was also used and given to qualified staff and consisted of thematic questions, on the following topics:

- Nursing role in pain assessment.
- General knowledge about pain.
- Knowledge of pharmacological management
- Knowledge of older people.
- Barriers to effective pain management as perceived by them.

The data collected from the questionnaires will be reported in another publication.

Data analysis

The method of analysis used for this study was content analysis (21). The qualitative information obtained from the residents' interviews and the staff discussion groups were transcribed verbatim and read through to highlight key issues. Further reading organised these issues into themes, these themes were checked by the investigator, and then verified by an independent reviewer. Ultimately, with content analysis the material could be analysed quantitatively using frequencies, however, with the small numbers in the study this was not appropriate.

RESULTS

A potential pool of two hundred and sixteen residents were identified from the six care homes, and from this number twenty-six were considered mentally competent to participate, according to the MMSE, and thus signed a consent to take part in the study. The mean age of the residents were 82 years (SD 9.1 Range 65-100). In this group, there were nine male and sixteen female residents. At the time of interview 85% were experiencing pain (n = 22). In spite of this result, 50% (n=13) were not taking any analgesic medication, and the rest were taking Paracetamol (n = 9) or Co-analgesics (Codeine + Paracetamol) (n = 4). The range of pain conditions included; arthritis, hip pain, multiple pains and leg ulcers. Arthritis affected 45% (n = 12) of the sample.

Resident interview themes

The data obtained from the resident interviews were grouped into four themes as follows:

- A reluctance to report pain/ acceptance that pain is normal and low expectations of help from medical interventions
- Fear of chemical or pharmacological interventions
- Age related perceptions of pain
- Lack of awareness of potential pain relieving strategies

Reluctance to report pain

During the interview, the investigator asked the residents “if they were in pain at the time”? Many residents were, but when asked why they had not reported the pain to the staff, they commented that there was no need to, as there was probably nothing that anyone could do. For example one patient commented that:

“it’s not unbearable, it just reminds me that its there, but there is nothing anyone can do so I do not grumble” (resident 7)

Yates and Fentiman (22) found in their study, that nursing home residents accepted pain as a companion of old age, and were therefore reticent of seeking help. Furthermore, a more recent study by Weiner and Rudy (23) suggested that older people appear to under-report pain, due to fears of worsening dependence. Within the current study this was highlighted by one resident who commented that

“what can you do? I just make the most of what I have at least I can still get around” (resident 6)

There have many studies that report the low expectations of help from medical interventions (24-26) and the current study was no exception. For example, when asked why she did not report her pain, resident 7 stated; “there is no point telling the staff, there is nothing they can do” A similar comment was made by resident 5 who said “there is nothing anyone can do to help”

Fear of chemical or pharmacological interventions

Many of the residents commented that they were fearful of using pharmacological interventions, and they would prefer to manage without them. When the investigator asked about taking tablets for pain, the residents would comment that they would rather manage without, or that nothing seemed to help. One resident commented that:

“she was living on drugs er tablets and did not really want to take anything else” (resident 5)

Weiner and Rudy (23) also highlighted these fears within their study, which they attributed to fears of addiction and dependence. It could be, that older people have to accept their increasing dependence upon others, when they go into a care home and to succumb to tablets, signifies worsening of their dependence.

Many of the residents commented upon the side effects of the drugs, and highlighted problems such as constipation, dizziness and sleepiness. It was interesting to note within the study, that many of the concerns related to drugs were expressed by the residents over the age of seventy-five, and the

investigator is curious whether this is related to the over seventy-five age group being prior to the inception of the health service, and therefore have grown up with self management strategies.

Schumacher et al (27) found similar findings in their study in which older people were reluctant to take analgesics for their cancer pain, as they perceived them as toxins. The patients in the Schumacher et al (27) study were younger with a mean age of 63 years, and it was an American study and therefore, within a different health care system. Also, the investigator does acknowledge that numbers in the current study were very small and therefore, it is difficult to draw any firm conclusions

Age related perceptions of pain

Not only were the older age group reluctant to take analgesics, but they were also reluctant to actually admit that they had pain. The residents under 75 years were more willing to voice their pain, and consequently to take analgesic drugs. These “younger” residents commented that

“one more tablet will not make any difference” (resident 2)

or that

“I used to buy things from the chemist when I was at home, but they do not like you to do that in here, so you have to ask them it really annoys me, why should I ask for them, I know when I am in pain, not them” (resident 3).

In contrast, the over 75 age group tended to listen to music or watch television and they avoided tablets which they called “chemicals” A study by Dunn and Horgas (28) demonstrated with their sample of 200 older people, that they accepted a range of coping strategies for pain management including both pharmacological and non-pharmacological. However, this study investigated older people’s methods of coping in the community, and as highlighted by Weiner and Rudy (23) with their study of nursing home residents, taking medication could signify further dependence. A further study by Sheffield et al (29) suggested that older people actually become desensitised to the pain after living with it for so long which could be one explanation.

Lack of awareness of potential pain relieving strategies

The residents interviewed did appear to be keen to be involved in their own pain management strategies. This was reflected in their comments of taking a hot bath or shower when the pain was bad, or “rubbing the affected area”. But generally the residents were unaware of approaches such as relaxation, massage or distraction. The study by Dunn and Horgas (28) highlighted that the behavioural coping strategies used by their sample were in order of priority; reporting pain, medication, diversion, exercise and heat. Interestingly, these findings are different to those in the current study, in which the over 75 age group appeared to prefer self management approaches, whilst the under 75’s opted for reporting and medication. The study by Lumme-Sandt et al (19) demonstrated how the “oldest old” in their sample accepted pain as part of aging, and held a high respect for the doctors and any prescriptions that they may or may not provide. The Lumme-Sande et al (19) sample were aged over 90, and there could be some

cultural differences in relation to pain and coping, as demonstrated in the classic study by Zborowski (30) who highlighted the vast cultural differences that can exist and consequently influence the pain threshold.

Staff interviews

Interviews with staff revealed the following themes:

- Knowing the residents are in pain.
- Doing more.
- Complementary therapies.

Knowing the residents are in pain

The staff explained that they often know when the residents are in pain based upon the fact that they get to know them really well over a period of months or even years. One staff member said, “you just know when they have pain, it is because you get used to them, our residents have been here for years and we know how they behave and the signs of them not being happy” (Trained staff member 1).

The study by Weiner and Rudy (23) supported this belief amongst nursing home staff in that the staff reported certain behaviours consistently as being representative of pain. Such behaviours included; grimacing, guarding, crying, whimpering and facial expression, along with agitation and aggression or as one staff member stated, “residents become irritable or confused and we know that there is something wrong, often this is pain” (Trained staff member 2).

There are increasing numbers of pain assessment tools that have been developed specifically for those who are cognitively impaired, all of which are based upon similar behaviours (31-34). A recent review identified eleven behavioural tools in total, but more testing is required to determine the psychometric properties of these tools (35).

Doing more

Many of the staff commented that they would like to do more, and this was related to both assessment and management strategies. Some staff have experienced the use of pain assessment tools in the acute setting and would like to see them put into practice within the care home. Those who have studied staff perceptions in care home settings do support the concept that the staff are keen to improve the situation, as found within the current study, but often time was a limiting factor (23,36,37) and others suggested that education within the care home setting was poor for all levels of staff.

The current study did identify a fairly good level of basic knowledge amongst staff, which is different to the Allcock et al (3) study. But they did not appreciate the potential of simple strategies such as making residents laugh as effective pain management. An issue highlighted also by Blomqvist (7). Therefore, further education would be needed to increase staff awareness of their contribution. A project is currently ongoing to introduce distance learning education on “pain in the older adult” into the care home setting (38).

Complementary therapies

The staff appeared to have an awareness of complementary therapies, and believed that they could make a valuable contribution to the care of the residents, by gaining further education in their use. Types of therapies

mentioned included; massage, aromatherapy, relaxation, distraction and Snoezelen. One staff member stated that “we often use distraction without realising it when we are doing dressing changes we use music for example” (Trained staff member 4).

As mentioned previously, Blomqvist (7) also found in her study that staff performed simple pain relieving strategies, without realising it, as part of their everyday practice. Of course, there is a danger that introducing new approaches may fail, in an area where staff shortages are part of everyday life. Therefore, recommendations for changes in practice must take into account poor staffing levels within the care home setting.

DISCUSSION

The results obtained in the current study must be viewed in light of the limitations. The sample of care homes was very small and could not therefore be considered representative of the care home population. Secondly, the investigator opted to interview residents without cognitive impairment, and others in the field have demonstrated that this group could be included (4) up to moderate levels of cognitive impairment. Furthermore, the sample of residents interviewed is also very small, and as such does not represent the care home population per se. However, in spite of these limitations, some interesting issues were highlighted.

From the current study we were able to conclude that pain is an issue for older people within the care home setting, which is not effectively recognised or dealt with by staff in a way that is acceptable for the residents. Furthermore, there are some staff misconceptions about pain in this population, which need to be addressed. Viewed with the limitations in mind, the current study does demonstrate areas for further research.

For example, a further study which identifies the older person’s preferred pain management strategies would inform practice, and help to develop an education package for both qualified and unqualified staff within the care home setting.

The two distinct age groups that appear to exist is interesting, with the younger ones being more accepting of intervention, in particular pharmacological intervention. This has not been highlighted before by other authors, and it could be that the older group lived prior to the introduction of the NHS, and therefore are more self-reliant than their younger counterparts. This would require further exploration in a larger study, before any firm conclusions could be made. Clearly, whatever the reason, this does suggest that there needs to be a range of pain management approaches on offer, and carers should not always focus upon pharmacological interventions.

The reticence of older people to acknowledge their pain is not something new, others within the literature have alluded to this (23) and it may be that the resident has grown tired of complaining to be told that nothing can be done, so they have become conditioned to “not complain”. An alternative perspective is that highlighted by Lumme-Sandt et al (19) in that some older people value stoicism, control, and fortitude or that of Dunn and Horgas (28), who demonstrated how some older people prefer to use their own religion as a way of coping. The issue of fear is not uncommon or unexpected. Many older people have a range of co-morbidities that require pharmacological interventions, and through experience, they may have learned that mixing tablets can cause unpleasant side effects. Alternatively, this could be an issue of lack of understanding or education, whereby the tablets have never actually been fully explained to the resident.

Finally the lack of knowledge of the alternative strategies is an interesting concept. Many health care professionals tend to focus upon pharmacological management and when this fails, they do not consider the other options. Therefore, the residents have probably never been given the choice of complementary or adjuvant approaches which could be used to enhance their current strategies.

CONCLUSIONS

This was a small scale exploratory study which viewed in the light of the limitations does appear to demonstrate some important issues. Much of the previous research has highlighted pain assessment issues with older people in care homes, and recommends the need for education.

Other studies do not appear to have explored pain management from the residents' perspective. This study does highlight that there are some important concerns amongst the residents themselves that have not been highlighted by staff. Such concerns have implications for the way that we approach the management of pain in care homes. Whilst, there is a wealth of literature advocating tailoring pain management to each person, it does not appear to address the individual needs of older people. Perhaps older people have been conditioned to "live" with pain, or accept that pharmacological approaches are the only option. Furthermore, many authors have made recommendations regarding the educational needs of staff, but what happens when the majority of staff are untrained, no-one has considered the important role that untrained staff could play in providing resident focussed strategies. Therefore, several recommendations can be made in the light of the current study as follows:

- Further research to include the residents with cognitive impairment and to determine their views and needs.
- Identify other approaches to pain management from the literature, (other than pharmacological) and discuss these with residents to determine their willingness to use such approaches, and ultimately to develop a resident focused pain management strategy.
- Develop an education package specifically for un-qualified staff to be implemented under the direct supervision of the qualified staff. To cover aspects of assessment and management of pain (39).

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