

NIH Pain Consortium

Centers of Excellence in Pain Education



Pain Assessment in Cognitively Impaired Older Adults

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Introduction

Pain is a very important factor in the management of all types of patients. This course focuses on an 80-year-old nursing home patient (Mr. Frank) and will improve your comfort in managing these patients from a pain perspective.

Learning Objectives

After completing this module, you should be able to:

- Apply strategies to recognize pain in the elderly non-verbal patient.
- Use tools to assess pain in this population with a focus on available measure, behavioral pain signature, and pain behaviors with emphasis on evaluation of other factors that may contribute to behavioral disruption.
- Develop non-pharmacologic strategies and medication selection in the medically complex older adult to treat pain.

Module Categories

The module features five categories:

- Initial Diagnosis
- Assessing Pain
- Managing Pain
- Evaluation Treatment
- Side Effects

Additional Information

Throughout the module, you'll find hyperlinks that take you to descriptions of various tools and related articles. These include the [PAINAD tool](#), [PACSLAC I](#), [PACSLAC II](#), [Comprehensive Pain Assessment](#), [Abbey Pain Scale](#), [Dangers of NSAIDs in Elderly](#), and [Care Transitions for Pain](#).

All of these links may also be found bundled together in the [Additional Information](#) portion of this document.

Welcome from Instructors

The following provides a description of the introduction to the module for pain assessment in cognitively impaired older adults:

Light background music plays throughout the video. The video begins when one of the course co-creators, Elizabeth Kvale, M.D., appears on camera. Her head and shoulders in the shot. She speaks directly to the viewer:

“I’m Elizabeth Kvale, an Associate Professor in Palliative Care at the University of Alabama at Birmingham.”

The image changes to reveal the head and shoulders of Alethia Sellers, M.D., C.M.Q., the second course co-creator.

She says, *“My name is Alethia Sellers, and I am an Assistant Professor in the Department of Anesthesiology and Perioperative Medicine.”*

The video continues to switch between head and shoulders shots of both Dr. Kvale and Dr. Sellers, as they each speak to the viewer.

Dr. Kvale continues, *“Welcome to Pain Assessment in Cognitively Impaired Older Adults.”*

Dr. Sellers describes the course as, *“A module made possible through our designation as an NIH Center of Excellence in Pain Education.”*

Dr. Kvale says, *“By the end of this module, you will be able to apply an assessment of pain in non-verbal older adults, demonstrate knowledge of*

management of mild, moderate, and severe pain in older adults with acute pain,

Dr. Sellers says, “and list the risks, side effects, and maintenance of opioid pain medication in older adults.”

Dr. Kvale says, “This module is designed for medical students in years one through three, advanced undergraduate in years one and two, masters nursing students.”

Dr. Sellers says, “Dental students in year three, students in year two of a doctoral physical therapy program.”

Dr. Kvale says, “And pharmacy students in year three.”

Dr. Sellers says, “The interactive module follows the story of Mr. Frank, an elderly non-verbal nursing home resident, experiencing pain. Mr. Frank has been admitted to the hospital, and you, the learner, will assist the interdisciplinary team with decisions around his care.”

Dr. Kvale says, “A geriatrician named Dr. Herrington serves as the voice of reason for the decisions proposed by the interdisciplinary team and selected by the learner.”

Dr. Sellers says, “The interdisciplinary team consists of Lily, the medical student; Moe, the social worker; Malcolm, the resident; and Victor, the nurse.”

Dr. Kvale says, “Please note that although the interdisciplinary team are all wearing white coats, they are not all representing physicians.”

Dr. Sellers says, “We provide for six decision points where Dr. Herrington asks a question and the interdisciplinary team provides a suggestion. The learner selects the best option, and will be either right, and continues on with the story.”

Dr. Kvale says, “Or wrong, and be redirected. We would encourage you to explore the various options and resulting outcomes throughout the module.”

Dr. Sellers says, “We also introduce three PAINAD practice videos.”

Dr. Kvale says, *“Where the learner uses the PAINAD assessment tool to determine the correct level of pain the patient is experiencing.”*

Dr. Sellers says, *“Wrong answers cause the learner to be cycled back. Other teaching elements are video lessons from Dr. Herrington, but they are not evaluated.”*

Dr. Kvale says, *“Enjoy!”*

Mr. Frank’s Test Results

Before beginning the first module category of Initial Diagnosis, review the following:

[Mr. Frank’s labs](#)

[CT scan](#)

[Mr. Frank’s medical history](#)

Initial Diagnosis

Initial Team Rounding

The following provides a description of the video of your peers, Victor, Lily, and Malcolm, as they discuss Mr. Frank's case:

Victor, Lily, and Malcolm stand in an empty hospital room with a bed and medical equipment in the background. It looks like they ducked in this room for privacy to discuss Mr. Frank's case.

Malcolm begins by asking Victor and Lily, *"All right, can you brief us on Mr. Frank?"*

"Certainly," Victor replies. *"So, Mr. Frank is very well known by the emergency department staff. He was brought into the emergency department. And when he came, he was very confrontational with the staff, which is out of character for him."*

"Mr. Frank is still agitated and combative," Lily adds, *"with no clear etiology. On physical exam on his admission with significant [inaudible] stage 3 decubitus ulcer on his sacrum."*

"Okay, thanks," Malcolm responds. *"Thank you both."*

Diagnosis

Now that you reviewed your peers' insights into Mr. Frank's case, what are some diagnoses you feel are appropriate to work up for Mr. Frank? Victor, Lily, and Malcolm give their responses below.

Victor: *"I would be thinking about infection, pain, and polypharmacy."*

Lily: *"Likely a CVA, atypical migraine, and brain tumor."*

Malcolm: *"I would consider tertiary syphilis, autoimmune encephalitis, or medication error."*

In this case, Victor's response of infection, pain, and polypharmacy seems the most reasonable answer for potential diagnosis of Mr. Frank's discomfort.

Pain Evaluation

Now that you've gone over Mr. Frank's medical history and physical, we can confirm he's at significant risk for pain, and this must be assessed. Which of your peers do you feel offers the best strategy to evaluate for pain in nonverbal older adults? Victor, Lily, and Malcolm offer their opinions below.

Victor: *"Utilize a functional MRI to evaluate whether someone is in pain."*

Lily: *"I've read about approaches to evaluating pain in non-verbal individuals. There are tools we can use."*

Malcolm: *"You can't really evaluate for pain, but we could try treating him to see if he gets better."*

Lily's thoughts on assessing pain offer the best strategy to assess Mr. Frank for pain.

Feedback

From reviewing Mr. Frank's history and physical, we can confirm he's at significant risk for pain, and this must be assessed. Fortunately, there are numerous tools to evaluate pain in this population. The main tool used in this module is the PAINAD¹.

¹ The PAINAD Assessment Tool can be accessed here:
http://www.mghpcs.org/eed_portal/Documents/Pain/Critical_Care/Dementia_Pain_Tool.pdf

The Pain Assessment Checklist for Seniors with Limited Ability to Communicate I and II, otherwise known as PACSLAC I² and PACSLAC II³ both provide a pain assessment checklist for seniors with limited ability to communicate. The Comprehensive Pain Assessment form⁴ lets you note details about pain location, duration, variations, and rhythm. The Abbey Pain Scale⁵ can also be used to measure pain in people with dementia who cannot verbalize.

² The PACSLAC I checklist can be accessed here: <http://gerocentral.org/wp-content/uploads/2013/12/Pain-Assessment-Checklist-for-Seniors-with-Limited-Ability-to-Communicate-PASLAC.pdf>

³ The PACSLAC II checklist can be accessed here: https://geriatricpain.org/sites/geriatricpain.org/files/wysiwyg_uploads/pacslac-ii_tool_with_logo.pdf

⁴ The Comprehensive Pain Assessment Form can be accessed here: https://geriatricpain.org/sites/geriatricpain.org/files/wysiwyg_uploads/comprehensive-pain-assessment-intact-tool_updated_2013.pdf

⁵ The Abbey Pain Scale can be accessed here: http://prc.coh.org/PainNOA/Abbey_Tool.pdf

PAINAD Practice

PAINAD Practice 1

The following provides a description of the video of Mr. Frank in his hospital bed:

Mr. Frank is shown propped up in his hospital bed. His torso rests at about thirty-degree angle from his lower body, supported by the inclined hospital bed. Dr. Herrington, the geriatrician, stands beside Mr. Frank's bedside, at his right shoulder. Both Dr. Herrington and Mr. Frank face the viewer.

As Mr. Frank appears comfortable in the hospital bed, Dr. Herrington describes his movements. *"So, we're going to score Mr. Frank's in the pain AD scale. So, looking at him, his breathing looks normal, it's not labored, it's not rapid. He's not vocalizing. He's just lying there calmly. His facial expressions, pretty normal. He's just kind of looking off in to the distance, not doing anything abnormal. His body language is very relaxed. He's a little bit restless and fidgety at times, playing with that towel, but otherwise he's doing fine, and there's no need to console him. He has no points for the consolability factor."*

Based on the above description, how would you rate Mr. Frank's pain in the PAINAD Practice 1 scenario using the PAINAD scale?

0 1 2 3 4 5 6 7 8 9

PAINAD Practice 2

The following provides a description of the video of Mr. Frank in his hospital bed:

The video begins by showing Mr. Frank in his hospital bed, his torso angled at about thirty-degree angle from his lower body.

Mr. Frank appears restless in his hospital bed. He uses his arms to shift himself around constantly, while making facial expressions that indicate discomfort. He can be heard making grunting sounds that echo discomfort as well.

Based on the above description, how would you rate Mr. Frank's pain in the PAINAD Practice 2 scenario using the PAINAD scale?

0 1 2 3 4 5 6 7 8 9

PAINAD Practice 3

The following provides a description of the video of Mr. Frank in his hospital bed:

The video begins by showing Mr. Frank in his hospital bed, his torso angled at about thirty-degree angle from his lower body.

Mr. Frank appears extremely restless and uncomfortable in his hospital bed. He uses his arms to arch his back and press his head deeply into the pillows on the bed, while making facial expressions that indicate a lot of discomfort. He can be heard making grunting sounds that echo extreme distress as well.

Based on the above description, how would you rate Mr. Frank's pain in the PAINAD Practice 3 scenario using the PAINAD scale?

0 1 2 3 4 5 6 7 8 9

Assessing Pain

Team Meeting 2

You've appropriately identified pain with Mr. Frank utilizing a formalized pain assessment tool.

Review the interdisciplinary team meeting in the video described below to learn about other sources that may indicate the presence of pain.

In this narrative, you'll notice Moe, the social worker, join Dr. Herrington, Victor, Lily, and Malcolm.

The following provides a description of the video of your Dr. Herrington, Moe, Victor, Lily, and Malcolm, as they discuss Mr. Frank's case:

Moe, Dr. Herrington, Victor, Lily, and Malcolm all stand clustered together in a wide hallway of the hospital that also serves as a meeting area and general communal space with chairs and tables in the background.

Dr. Herrington starts by saying, *"So Mr. Frank is showing signs of pain. Besides using formal pain assessment scales like the PAINAD, let's think about some other strategies we can use."*

Victor replies, *"When I worked at One Manor with Memory Disorder Unit, we would look at these patient populations and we'd find trends with the pain. So maybe we could do the same thing here and look for pain in this patient population."*

The social worker, Moe, adds, *"You know I have a good relationship with the nursing staff over at One Manor, I could give them a call and see if the behavior that Mr. Frank is displaying today is kind of similar to some behavior that he does when he's pain at the nursing home."*

Victor brightens at this idea and says, *"I think that'd be a great idea, Moe. If you wouldn't mind doing that right now then just reporting back to us by end of our IDT, we could use that information in treating this patient better."*

Moe responds, “*Okay.*”

Quiz Questions

Quiz Question 1

Which of the following may be an unrecognized factor contributing to behavioral disturbance in older adults?

1. [Pain](#)
2. [Medication change](#)
3. [Urinary retention](#)
4. [Constipation](#)
5. [All of the selections](#)

Quiz Question 2

True or false? Using a formalized pain assessment tool for nonverbal adults is better than guessing.

1. [True](#)
2. [False](#)

Quiz Question 3

Which of the following is a reasonable tool to use to assess pain in non-verbal adults?

1. [The zero to ten pain scale](#)
2. [The “mild, moderate, severe” subjective pain scale](#)
3. [The PAINAD](#)
4. [The WHO ladder](#)

Non-pharmacologic Options

Review the description of the interdisciplinary meeting below to find out what Moe, the social worker, discovered after reaching out to Mr. Frank's nursing home caretakers.

The following provides a description of the video of Dr. Herrington, Moe, Victor, Lily, and Malcolm, as they discuss Mr. Frank's case:

Moe, Dr. Herrington, Victor, Lily, and Malcolm all stand clustered together in a wide hallway of the hospital that also serves as a meeting area and general communal space with chairs and tables in the background. Moe just rejoined the group after reaching out to Mr. Frank's nursing home, One Manor. He wanted to see if he could discover any incidences in the past at the nursing home when Mr. Frank displayed similar behavior in acting out, and what may have caused it.

Dr. Herrington asks, *"So, what did you find out?"*

Moe replies, *"Well, after I spoke with the nurse at One Manor, she said that in the past, he'd become combative after a fall, when he was in pain."*

Dr. Herrington responds, *"Okay. Well, good job, team. Now that we know he's in pain, let's address it."*

Each of your peers came up with a non-pharmacologic approach to help ease Mr. Frank's pain.

Victor: *"We could reposition him so he's not lying on the wound."*

Lily: *"We could try physical therapy."*

Malcolm: *"We could find out what kind of music or scent selections could be soothing to him."*

Other non-pharmacologic options to help ease discomfort in elderly non-verbal patients could include:

- Acupuncture
- Heat
- Hypnosis
- Ice
- Massage therapy
- Pet therapy
- Spinal cord stimulation
- Transcutaneous electrical nerve stimulation (TENS)

First Line Options

Decision Point 1

What do you feel might be a good first line treatment for Mr. Frank?
Choose the colleague with the best answer.

Lily: “Maybe a non-steroidal anti-inflammatory?”

Victor: “I’ve seen a lot of patients here on scheduled Tylenol.”

Feedback

According to Dr. Herrington, Tylenol, or acetaminophen, is the best choice first line option for Mr. Frank. But you should exercise caution when prescribing Tylenol for continuous pain control.

Non-steroidal anti-inflammatories can be dangerous for elderly patients. To learn more about harmful side effects, review the ‘Dangers of NSAIDs in Elderly’ article here:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2280786/pdf/canfamps00157-0213.pdf>

Managing Pain

Medication Options

Decision Point 2

Even though he started the scheduled Tylenol, Mr. Frank still looks considerably uncomfortable.

Which medication option from your peers' suggestions seems best to help put Mr. Frank more at ease?

Victor: "We usually see low dose oxycodone or morphine used for older adults with pain that have not responded to Tylenol."

Malcolm: "A pain patch may be convenient. How about a fentanyl 25 mcg patch?"

Lily: "We could order Norco 10 mg."

WHO Analgesic Ladder

After reviewing the WHO Analgesic Ladder video description, you'll know more about scheduling a pain medication and adjuvant therapy.

The following provides a description of the video of the WHO Analgesic Ladder:

The video starts by showing an animation of a pyramid-shaped model to represent the WHO Analgesic Ladder. The bottom level of the model is colored purple, and shows the number one along with the description of "pain." A label beside the bottom level, also colored purple, lists the words, "Non-opioid, plus or minus non-opioid, (and) plus or minus adjuvant."

The second level up from the bottom of the pyramid is colored blue, and shows the number two along with the description of "pain persisting or increasing." The label beside this level, also colored blue, lists the words,

“Opioid for mild to moderate pain, plus or minus non-opioid, (and) plus or minus adjuvant.”

The third level from the bottom of the pyramid shape is colored orange, and shows the number three, along with the description of “Pain persisting or increasing.” The label beside this level is colored orange as well, and shows the words, “Opioid for moderate to severe pain, plus or minus non-opioid, (and) plus or minus adjuvant.”

The top level of the pyramid is colored pink, and shows the description, “Freedom from cancer pain.”

The voice over narrative provides the following accompanying audio:

“The World Health Organization provides a model for addressing acute pain. The model was developed with cancer pain in mind but has the application to other sources of acute pain. It should be noted that application to chronic pain has not been established.

You'll observe that the World Health Organization ladder provides a structured stepwise approach to the management of acute pain. Starting with the use of non-opioid strategies such as acetaminophen or non-steroidal anti-inflammatory medications with or without adjuvant strategies.

We'll introduce some adjuvant strategies in just a moment, but I want you to understand that the World Health Organization ladder works on several basic principles. One is the oral administration of analgesics. The oral form of medication should be used whenever possible. Analgesics should be given at regular intervals. To relieve pain adequately, it's necessary to respect the duration of the medication's efficacy. Analgesics should be prescribed according to pain intensity and as evaluated by a scale of intensity of pain.

What you see here with the ladder is that if pain is persisting or increasing after the first step, you move to the second step where you might use that opioid for mild or moderate pain. And similarly, if that's not helpful to your patient and they have persisting or increasing pain, you move further up the ladder. Dosing of pain medication should be adapted to the individual. There's no standardized dosage in the treatment of pain

because each patient will respond differently. Now I want to move to talking about adjuvant strategies.”

At this point in the narrative, the image on the screen changes to show five boxes on the left side of the screen. From top the top left corner, four of the squares are colored pink, orange, purple, and blue in clockwise order. The fifth square sits in the middle of the other four squares, and is colored yellow.

The pink square is titled, “Physical,” and includes the description, “Pain due to disease location. Other symptoms, e.g., nausea; physical decline and fatigue.”

The orange square is titled, “Social,” and includes the description, “Relationships with family (and) careers; role in family; work life; financial problems.”

The purple square is titled, “Spiritual,” and includes the description, “Existential issues; religious faith; meaning of life and illness; personal value as a human being.”

The blue square is titled, “Psychological,” and includes the description, “Grief, depression, anxiety, anger, adjustment to condition.”

The yellow square in the middle is simply titled, “Pain,” as the overarching theme of the other squares.

The right side of the screen shows the breakdown of examples of “Adjuvant Pain Strategies Physical.” Underneath that headline are the following examples:

Neuropathic agents: gabapentin, pregabalin, tricyclic antidepressants

Psychological: antidepressants to address untreated or undertreated depression or anxiety; talk therapy to address adjustment reactions, cognitive reframing

Social: family therapy to address impact on family role; occupation therapy to address impact on function, work

Spiritual: assessment for sources of existential pain; meaning of life and illness; mindfulness approaches to enhance resilience and meaning

Once the screen image changes to display the above visual description, the voice over narrative conveys the following audio:

“The concept of total pain was developed to help understand the multi-factorial nature of the pain experienced. It encompasses not just the physical components of pain but also the social, psychological, and spiritual components of pain, and adjuvant strategies may address any of these domains.

For example, neuropathic agents help to address physical pain that's not responsive to opioid pain medications. Psychological strategies may include anti-depressants to address untreated or undertreated depression or anxiety or talk therapy. An approach to social pain may include family therapy to address the impact on family role or occupational therapy or similar approaches. Addressing spiritual pain may mean assessment for sources of existential pain, exploration of the meaning of life and pain or mindfulness approaches to enhance resilience and meaning.”

Medication Dosing and Scheduling

Once you've reviewed the description of the video about pain medication dosing and scheduling, test your knowledge with the quiz questions that immediately follow.

The following provides a description of the video of Medication Dosing and Scheduling:

The image on the screen shows the title “Pain Management Basics.” Under the title, the following words appear:

- Opioid Pharmacology
- T to Cmax
 - po dosing – 1 hour
 - sc/IM dosing – 30 minutes
 - IV dosing – 6 minutes

- How long should you wait to re-evaluation a patient with pain?
 - po dosing – 1 hour
 - sc/IM dosing – 30 minutes
 - IV dosing – 6 minutes

The following narrative accompanies the text on the screen:

“Determining when to reevaluate the effectiveness of pain medication is guided by the time to peak serum concentration (or Cmax) which is determined by dosing route with commonly used opioid medications. When a pain medication is orally dosed, it is reasonable to recheck the patient in one hour to see if they are benefiting with improvement in pain. If the dose is subcutaneous or intramuscular the time to peak serum concentration is shorter, and it is reasonable to reevaluate the patient as early as 30 minutes after the dose.

If the dose is intravenous, as would often be the case for a patient in severe pain, you only need to wait 6 minutes to evaluate the effect of the medication. In treating acute pain, if the medication is not effective at peak serum concentration it is reasonable and safe to give additional pain medication at that point without waiting an additional 4 hours – however one must be careful not to overlap doses by not waiting until the medication has reached peak serum concentration.”

The image on the screen changes to show the same title “Pain Management Basics,” with updated text below it. Under the title, the following words appear:

- Steady state after 4-5 half-lives
 - steady state after 1 day (24 hours)

The following narrative accompanies the text on the screen:

“Steady state is when the overall intake of a drug is in balance with its elimination. Pain medications achieve steady state after 4 to 5 half-lives, and commonly used opioids achieve steady state after 24 hours. This is NOT TRUE for methadone, and it is recommended that providers who are not expert in the pharmacokinetics and use of methadone avoid it.

Clinically what this means is that if patients have been routinely dosing opioids over 24 hours and have achieved adequate pain control, you can calculate how much pain medication they need to accomplish adequate pain control by summing all the doses they have required over the 24 hours.”

The image on the screen changes to show the same title “Pain Management Basics,” with updated text below it. Under the title, the following words appear:

- Routine oral dosing
 - Immediate-release preparations duration of effect is 4 hours
- Hydrocodone, morphine, hydromorphone, oxycodone
 - Dose every 4 hours
 - Adjust dose daily
 - Mild to moderate pain, 25%-50% more
 - Severe to uncontrolled pain, 50%-100% more
 - Adjust more quickly for severe uncontrolled pain

The following narrative accompanies the text on the screen:

*“The duration of effect of most immediate release pain medications alone or in combination with acetaminophen is 3-5 hours. The most appropriate dosing window for these medications when a patient has ongoing pain is therefore 4 hours. While 6 hours is often used as a dosing interval for pain medication in the hospital it is not appropriate for patients who have constant pain because they are **LIKELY** to have a period of poor pain control before their next dose is available. A six-hour dosing window is most appropriate for patients with truly intermittent pain.”*

The image on the screen changes to show the title “Logistics of ‘as needed’ medications in hospital.” Under the title, the following words appear:

- Long delays may occur when patients are provided with as needed medications in hospital
- Patients may wait up to an hour or longer to receive a dose after requesting a pain medication
 - Older patients, stoic patients and clearly non-verbal patients may be unable to request pain medications
 - Consider routinely scheduling medications every four hours that patients may decline – check to see if your facility has an ‘offer may refuse’ scheduling

The following narrative accompanies the text on the screen:

“When patients are hospitalized there are frequent delays from when they request pain medication to when they actually receive it that can negatively impact their pain control and patient experience. Some patients are hesitant to ask for pain medication.

One logistical approach to this issue is to ask nurses to check with especially vulnerable patients every four hours to see if they need pain medication. In some institutions this scheduling option is called ‘offer may refuse.’”

Quiz Questions

Quiz Question 1

Which of the following adverse events is NOT commonly associated with the use of nonsteroidal anti-inflammatories in older adults?

1. [Renal failure](#)
2. [Gastrointestinal bleeding](#)
3. [Heart failure](#)
4. [Leukocytosis](#)

Quiz Question 2

Mrs. Wright is a 78-year-old woman experiencing night time pain her bilateral knees, especially on days she spends a long time in the garden. She currently takes no medication. What's a reasonable first step to address her discomfort?

1. [Fentanyl patch](#)
2. [Low dose methadone](#)
3. [Tramadol](#)
4. [Acetaminophen](#)

Quiz Question 3

All of the following are reasonable non-pharmacologic approaches to pain and may be adjunctive pain management strategies except:

1. [Massage](#)
2. [Mindfulness meditation](#)
3. [Surgery](#)
4. [Acupuncture](#)
5. [Cold/heat](#)

Evaluating Treatment

Team Rounding 2

Review the description of the team rounding to learn the latest news about Mr. Frank.

The following provides a description of the video of Dr. Herrington meeting with your peers, Victor, Lily, and Malcolm, as they review Mr. Frank's case:

Dr. Herrington, Malcolm, Lily, and Victor stand in an empty hospital room with a bed and medical equipment in the background. It looks like they ducked in this room for privacy to discuss Mr. Frank's case.

Dr. Herrington asks the group, *"So, how's Mr. Frank this morning?"*

Victor replies, *"Mr. Frank had a couple of great intervening days. He's been restful, he hasn't been combative and his family said he's been at baseline. But unfortunately today, it just seems like he's having increasing agitation and decreased p.o. intake. Actually, Lily was telling me earlier about how he was really aggressive with one of the aides today."*

"Yeah, Mr. Frank doesn't seem like himself today. He's not eating, he's agitated, his wound is dressed nicely and doesn't appear any worse and his vitals are stable. We got a UA and a blood culture that's pending. His chest x-ray, CBC, and electrolytes were all normal, so that's all I got," Malcolm adds.

Dr. Herrington nods and says, "Okay, well good for you guys for picking up on that subtle change because too often we miss those things. What else did you notice on exam?"

Malcom says, *"For the most part, it's unchanged."*

Lily disagrees and says, *"Well, I thought his tummy was a little distended." Malcolm considers this and sides with Lily. "Well, now that you've mentioned it, it was slightly distended."*

Dr. Herrington nods her approval. *"Okay, well that's why we work in teams. Let's go check."*

“Okay,” Malcolm says.

IDT Explained

The following video description explains why interdisciplinary teams are so important to help treat pain.

The video opens with a purple box on a pink background. Text in the purple box reads “total pain.” Next, a white box with the word “nurses” appears above the purple box. Throughout the rest of the video, additional boxes colored a darker pink pop up around the original purple box. Clockwise from the upper right corner, they read, “Chaplain, psychologist, social work, physical therapist, pharmacist, (and) prescribing provider.”

The following is a transcription of the narrative of the video:

“Speaking of teamwork, I want to talk for a minute about why interdisciplinary teams are so important in the management of pain. And that means returning to the concept of total pain, which is a construct we talked about before, which characterizes the multi-dimensional nature of the pain experience and includes the physical, psychological, social, and spiritual components of pain.

Nurses and patient care techs have more face time with patients in the inpatient setting than most other providers. They’re excellent observers of behavior and can monitor response to interventions. More than other team members, they may have a sense of what factors contribute to a patient’s total pain. For example, if they perceive that the patient is having a lot of existential suffering it may be helpful to engage a chaplain in care.

Similarly, if the patient needs to develop better coping skills or reframe the nature of their pain a psychologist or a social worker may be helpful. Social workers also have expertise in dealing with family dysfunction.

Physical therapists can add a component of physical management of pain and return to function. Pharmacists can collaborate with a prescribing provider to ensure that we develop safe regimes to address a patient’s total pain.”

Team Rounding 3

Review the description of the team rounding to learn the updated news about Mr. Frank.

The following provides a description of the video of peers, Victor, Lily, and Malcolm, as they review Mr. Frank's case:

Dr. Herrington, Malcolm, Lily, and Victor stand in an empty hospital room with a bed and medical equipment in the background. It looks like they ducked in this room for privacy to discuss Mr. Frank's case.

Malcolm begins, *"Well, Lily, his belly does seem a little distended. Has Mr. Frank been urinating?"*

"Yes," Victor responds. *"In fact, his diaper was wet when we examined him today, but we even changed him twice last night, according to our sign out."*

"Okay," Malcolm replies. *"When's the last time he had a bowel movement?"* *"It was not this shift,"* Victor says. *"And, in fact, there's no mention of it in night's report. I just picked him up again, but let me go check."*

"Okay," Malcolm acknowledges. *"While you do that, let's think about how the side effects of opioids might be contributing to this clinical picture, okay?"* Victor and Lily nod in agreement.

Opioid Side Effects

Common side effects of opioids include the following:

- Confusion
- Constipation
- Itching
- Lethargy
- Nausea
- Opioid induced hyperalgesia
- Respiratory depression
- Sleepiness
- Urinary retention

Matching Side Effects with Affected Organs

Choose which organ each side effect affects.

What organ does bradycardia and hypotension affect?

- [Brain](#)
- [Heart, cardiac](#)
- [Histamine release from a mast cell, immune system](#)
- [Skeletal, muscle](#)
- [Stomach, bowel](#)

What organ does drowsiness, sedation, and hallucinating affect?

- [Brain](#)
- [Heart, cardiac](#)
- [Histamine release from a mast cell, immune system](#)
- [Skeletal, muscle](#)
- [Stomach, bowel](#)

What organ does nausea and constipation affect?

- [Brain](#)
- [Heart, cardiac](#)
- [Histamine release from a mast cell, immune system](#)
- [Skeletal, muscle](#)
- [Stomach, bowel](#)

What organ does myoclonus affect?

- [Brain](#)
- [Heart, cardiac](#)
- [Histamine release from a mast cell, immune system](#)
- [Skeletal, muscle](#)
- [Stomach, bowel](#)

What organ does pruritis affect?

- [Brain](#)
- [Heart, cardiac](#)
- [Histamine release from a mast cell, immune system](#)
- [Skeletal, muscle](#)
- [Stomach, bowel](#)

What organ does respiratory depression affect?

- [Brain](#)
- [Heart, cardiac](#)
- [Histamine release from a mast cell, immune system](#)
- [Skeletal, muscle](#)
- [Stomach, bowel](#)

Treatment

Decision Point 3

Your colleagues noticed Mr. Frank is in discomfort and his stomach appears distended.

Choose what you feel to be the best answer to address this situation.

Victor: “We can get a bedside bladder scan for residual, even though he’s had wet diapers.”

Lily: “He could be nauseated from the opioids. If we think he still needs them, could we try a different opioid?”

Malcolm: “If he’s constipated, we may want to adjust his bowel regimen. I noticed he’s only on a fiber laxative.”

Side Effects

Constipation and Delirium

It appears as though Mr. Frank may be constipated due to the opioids he's taking. Constipation may cause delirium and confusion. The following video description helps explain this phenomenon.

The video opens with the title, "Protocol: Evaluation and Work-Up for Delirium." Under the title, the following notations appears:

- Discuss mental status changes and other associated symptoms with patient and caregiver. Identify and remove any triggers if possible.
- Review the patient's medicines, especially looking for new medicines or psychoactive medicines (Beer's list).
- Ask about medicines or other drugs that were recently stopped (benzodiazepines, alcohol, etc).
- Perform a thorough exam, evaluating for and treating underlying pain or discomfort.
- Check for fecal impaction and dis-impact as needed.
- Evaluate for urinary retention: physical exam, then bladder scan or straight catheter if retention is suspected.
- Avoid restraints: remove them if present.
- If urinary symptoms are present, consider checking UA and culture.
- Depending on patient's associated symptoms, baseline function and goals, consider checking other labs, cxr, etc.

The following narrative accompanies the text on screen:

"I know, I know. You did not sign up to do a module on delirium, but here's the thing: older adults, and especially frail older adults, frequently don't present complaining of pain. They present confused and then you have to figure out what's going on. So that includes discussing mental status changes and other associated symptoms with the patient and the caregiver, reviewing medications especially new medications or psychoactive medications, and asking about medications and drugs that

were recently stopped especially those that may incite a withdrawal syndrome.

You want to perform throughout exam, evaluating for and treating underlying pain and discomfort. But you can't stop there because often times delirium is not a single issue, its multi-factorial, so you have to do things like check for fecal impaction, consider urinary retention, avoid restraints and orient the patient.

If urinary symptoms are present consider checking a UA, and, depending on associated symptoms, doing a thorough workup to think about other things that might be going on."

Addressing Constipation

Decision Point 4

Mr. Frank appears to be constipated. Addressing his constipation should be our first option.

Your peers have suggested a number of different options below. Choose the answer you feel is the best solution.

Malcolm: "Mag Citrate. He's been here 5 days. It's time to break out the dynamite."

Lily: "I think I would check him for impaction, maybe try a suppository, and make sure we start him on both a stool softener and a bowel stimulant."

Victor: "I read about a new medication for opioid induced constipation. Well, actually, it was a commercial on TV, but it seems like it might be applicable here."

Starting a Bowel Regimen

It's important to establish a bowel regimen for someone on opioids, like Mr. Frank. Review the video description to learn when to start a bowel regimen, and what strategies to use to select one.

The video opens with two dark green boxes on the left-hand side of the screen, against a light brown background. They each contain a word: "When?" and "What?"

The following narrative accompanies the text on the screen:

"There are really 2 questions that you need to be prepared to address when you are thinking about starting a bowel regimen for somebody on opioids." A dark green arrow pointing to the right appears beside the first dark green box with the word "When." On the right side of the screen, a new light green box appears to the right of the arrow now pointing to it. It reads, "Now!" The narrative continues with, "The first is 'whe'n and the answer to that is really easy, its 'right now.'"

As soon as you start an opioid regimen for a patient you should be thinking about a bowel regimen. It's a side effect that patients never adapt to. What is only just a little bit trickier, despite the fact that there is little published evidence to guide decision making around which bowel regimen to use. A dark green arrow pointing to the right appears beside the second dark green box with the word "When." On the right side of the screen, a new light green box appears to the right of the arrow now pointing to it. It reads, "Stool softener (plus) a stimulant." The narrative continues with, "The standard of care is the utilization of a stool softener plus a stimulant."

Two additional green boxes appear in the middle of the bottom of the screen. The first shows the title, "Softener: Osmotic agents. Draw fluid into the colon."

Under the title follow the words:

- Lactulose
- Sorbitol
- Polyethylene glycol
- Lubriporstone⁶

The second box shows the title, “Stimulants: Increase muscle contractions.”

Under the title follow the words:

- Senna
- Dulcolax

The narrative continues, “*Softeners are typically osmotic agents that draw fluid into the colon and stimulants increase muscle contractions. There are also newer agents that work by blocking opioid receptors in the gut, but they’re expensive and they should be considered second line agents and used only when the other regimens are not effective.*”

Team Rounding 4

Let’s check in to see what your colleagues say about Mr. Frank’s response to treatment. A review of the video of their discussion follows.

The following provides a description of the video of Dr. Herrington meeting with your peers, Victor, Lily, and Malcolm, as they review Mr. Frank’s case:

Dr. Herrington, Victor, Lily, and Malcolm all stand clustered together in a wide hallway of the hospital that also serves as a meeting area and general communal space with chairs and tables in the background.

Dr. Herrington asks, “*So Lily tell us about Mr. Frank.*”

⁶ There are newer agents that work by blocking opioid receptors in the gut including methylnaltrexone and naloxegol. They are expensive and are second line agents that should be used if other strategies are ineffective.

Lily responds, *“Well Mr. Frank has been back at baseline for over 24 hours. He's required two to three doses of pain medication over the past two days. His bowel movements are back to normal and his wound is pink and granulating.”*

“Wonderful,” Dr. Herrington replies. *“That's great progress. So now I feel safe discharging him to One Manor. But how do we make sure that his pain's controlled when he's there?”*

Care Transitions

Care transitions for patients requiring pain management can be tricky. Review the video description below to learn strategies to achieve the best transition possible. You may also click this link to review the implementation guide:

<http://www.scupstateadrc.org/Portals/14/docs/Project%20BOOST%20Implementation%20Guide.pdf>

The video shows a graphic of a clipboard on the left-hand side of the screen. The right side of the screen beside the clipboard graphic shows the title for the visual portion of the video, “Care Transitions for Patients Who Need Opioids: Checklist for a Quality Pain Management Discharge.”

The following bullet points can be seen on the clipboard graphic:

- Identify outpatient provider who is willing to prescribe opioids.
- Run a prescription drug monitoring program (PDMP) report to identify concerning fill patterns, e.g. multiple providers, multiple pharmacies.
- Ensure that outpatient provider is comfortable with discharge regimen.
- Check that an appointment is scheduled with outpatient pain provider.
- Ensure that pain is stable on discharge regimen for at least 24 hours.
- Ensure that insurance will cover any new medications.

- Check with pharmacy where patient plans to fill prescription to ensure that they have sufficient supply to fill the discharge prescription.
- Give the patient a follow-up number where patient or pharmacy can call the prescribing provider for any problems with the discharge prescription.
- Use the teach-back method to ensure that patient understands how to take medications after discharge.
- Give the patient a phone number to call for questions about how to take medications or increased pain.

The following narrative accompanies the text onscreen:

“Care transitions for persons who require pain management can be especially tricky, for example if your patient is routinely requiring opioid pain medications during their hospitalization and they’re discharged without pain medication, there’s a high probability of re-admission, not a good outcome.

At the same time, prescribing clinicians need to be cognizant of the risks of opioid medication including the risk of addiction and diversion. Care Transitions when Opioids are involved call for a patient-centered approach to care and a commitment to meeting our patients’ needs in the safest way possible. Hallmarks of excellent care transitions include patient and family education about new medications including expected length of use, and expected benefits and risks of the plan.

Patients need close follow up for re-evaluation, most appropriately with a clinician who will take over responsibility for their pain as a medical problem. Patients should be scheduled for followed up appointment within a week of discharge when possible. If patients need to be discharged with opioid pain medications, the prescriber should provide enough medications so that the patient can get to the scheduled appointment, without running out.”

The narrative then reads verbatim through the bullet points listed above on the clipboard graphic.

Quiz Questions

Quiz Question 1

Potential adverse effects of opioid pain medications include which of the following?

- Constipation
- Confusion
- Urinary retention
- Addiction
- Respiratory suppression

Quiz Question 2:

True or False? The most appropriate time to provide a bowel regimen is the same time that you provide a prescription for opioid pain medications.

- True
- False

Quiz Question 3:

True or False? Mr. Frank should have a follow-up to his hospitalization to ensure his pain resolved.

- True
- False

Congratulations

Congratulations on finishing the module! Once Mr. Frank transitions back to his nursing home, he should be more comfortable with his customized pain management plan.

Additional Information

Mr. Frank's Medical History

Mr. Frank is an 80-year-old nursing home resident. Recent years have been marked by progressive cognitive decline attributed to Alzheimer's disease. Over the past 12 months he has become non-ambulatory and now uses few words most often out of context. He does still feed himself and swallows without difficulty. He is typically "pleasantly confused" and compliant with staff guidance and care.

Mr. Frank was previously a primary school teacher and was well-loved within his community. His husband Bennie passed away in his late 60's. They have one adult daughter who visits regularly but does not live nearby. His daily care is provided by the nursing home staff.

2 days prior to admission, the nursing home staff noted decreased oral intake and resistance to care but were able to dose usual medications. This progressed over the subsequent day with Mr. Frank noted to be agitated, resistant to care and uncharacteristically aggressive – striking out at the aid who came to clean him up after breakfast. Transfer to acute care facility was arranged after Mr. Frank fell from his chair.

Mr. Frank was evaluated in the emergency department prior to admission. His medication list is below:

Medications:

Docusate sodium 100 mg daily

Donepezil 10 mg daily

Memantine 10 mg BID

Physical Exam

VS: BP 110/78; pulse 110; Respirations 18

General: Clean but slightly disheveled older male, no acute distress. Does not respond to questions, appears alert but inattentive.

HEENT: No contusion or indication of trauma, PEERL, fundoscopic exam with normal optic vessels and disc, face symmetrical, tongue midline

Neck: no mass, lesion or point tenderness.

Chest: Good air movement, no crackles or wheezes

CV: RRR, rate 110, no murmur, extra sounds or rub

Abd: normoactive bowel sounds, soft, no organomegaly or tenderness. No costovertebral angle tenderness.

Rectal exam: No mass, no impaction, heme negative stool

GU: No lesion or mass

Extremities: mild ecchymosis R elbow, ROM all joints without evidence of discomfort, some resistance to exam.

Skin: Sacral stage 3, red base no purulence, patient with obvious discomfort when examined. Mild tenting of forearm skin. Work up ordered by emergency physician include CBC, chemistry, UA, blood cultures, toxicology, chest X-ray, computed tomography (CT) head.

He was admitted for further evaluation. Initial efforts have included parenteral hydration and empiric antibiotics.

Mr. Frank's Labs

Patient information:

Name: Charles Thomas Frank

Gender: male

Date of birth: 09/12/1935

Age: 80

Address: 2018 Victory Road, Sochi, AL 61418

UA with Reflex Culture (final result)

ID: 16WC-162U0052

Type: urine

Source: urine, clean catch

Authorized by: Herrington, Heather E, MD

Status: final result

Collected: 7/1/2016 0950

Received: 7/1/2016 1010

Verified: 7/1/2016 1045

Resulting lab: STLO LAB

Color UA: *Straw (A)*. Reference range: *pale to dark yellow*.

Clarity UA: *Clear*. Reference range: *Clear*.

CBC w Diff (final result):

ID: 15WC-336H0753

Type: blood

Authorized by: Kvale, External Provider

Status: final result

Collected: 7/1/2016 1138

Received: 7/1/2016 1201

Verified: 7/1/2016 1409

Resulting Lab: STLO LAB

WBC: 5.5. Reference range: 4.0-9.5 K/uL.

RBC: 4.59. Reference range: 3.90-4.90 M/uL.

Hemoglobin: 14.1. Reference range: 11.8-14.8 g/dL.

Hematocrit: 42.3. Reference range: 35.5-44.0%.

MCV: 92.2. Reference range: 82.0-99.0 fL.

MCH: 30.7. Reference range: 27.2-32.6 pg.

MCHC: 33.3. Reference range: 30.0-36.0 g/dL.

RDW: 13.3. Reference range: 11.5-14.5%.

RDW-9TDEV: 44.4. Reference range: 37.1-48.7 IL.

Platelets: 187. Reference range: 140-350 K/uL.

MPV: 12.1. Reference range: 9.3-12.4 fL.

Neutrophils: 48. Reference range: 45-70%.

Lymphocytes: 39. Reference range: 16-45%.

Monocytes: 8. Reference range: 3-13%.

Eosinophils: 6. Reference range: <7%.

Basophils: 0. Reference range: <3%.

Neutrophil absolute: 2.62. Reference range: 1.90-7.00 K/uL.

Lymphocyte absolute: 2.11. Reference range: 0.70-4.50 K/uL.

Monocyte absolute: 0.41. Reference range: 0.10-1.30 K/uL.

Eosinophils absolute: 0.30. Reference range: <0.70 K/uL.

Basophils absolute: 0.02. Reference range: <0.30 K/uL.

Comp. Metabolic Pnl (final result):

Patient: Charles T. Frank

ID: 15WC-336H0753

Type: blood

Authorized by: Callans, External Provider

Status: final result

Collected: 7/1/2016

Received 7/1/2016

Verified: 7/1/2016

Resulting Lab: STLO LAB

Sodium: 144. Reference range: 136-145 mmol/L.

Potassium: 4.9. Reference rang: 3.5-5.0 mmol/L.

Chloride: 106. Reference range: 98-107 mmol/L.

CO2: 25. Reference range: 22-29 mmol/L.

Calcium: 9.3. Reference range: 8.6-10.2 mg/dL.

Bun: 23. Reference range: 8-23 mg/dL.

Creatinine: 0.83. Reference range: 0.51-0.95mg/dL.

Glucose: 98. Reference range: 79-99 mg/dL.

Total protein: 7.1. Reference range: 6.7-8.6 g/dL.

Albumin: 4.5. Reference range: 3.5-5.2 mg/dL.

Bilirubin total: 0.3. Reference range: 0.2-1.1 mg/dL.

Alkaline phosphatase: 60. Reference range: 35-104 U/L.

AST: 20. Reference range: <33 U/L.

ALT: 21. Reference range: <34 U/L.

The **GFR** result is not clinically significant on patients <18 or >70 years of age.

Mr. Frank's CT Scan

Access the image of Mr. Frank's CT scan here:

<http://painmeded.com/wp-content/uploads/2017/08/Mr.-Franks-CT-HEAD-2.png>

PAINAD

Access the PAINAD here:

http://www.mghpcs.org/eed_portal/Documents/Pain/Critical_Care/Dementia_Pain_Tool.pdf

PACSLAC I

Access the PACSLAC I here:

<http://gerocentral.org/wp-content/uploads/2013/12/Pain-Assessment-Checklist-for-Seniors-with-Limited-Ability-to-Communicate-PASLAC.pdf>

PACSLAC II

Access the PACSLAC II here:

https://geriatricpain.org/sites/geriatricpain.org/files/wysiwyg_uploads/pacslac-ii_tool_with_logo.pdf

Comprehensive Pain Assessment

Access the Comprehensive Pain Assessment form here:

https://geriatricpain.org/sites/geriatricpain.org/files/wysiwyg_uploads/comprehensive-pain-assessment-intact-tool_updated_2013.pdf

Abbey Pain Scale

Access the Abbey Pain Scale here:

http://prc.coh.org/PainNOA/Abbey_Tool.pdf

Dangers of NSAIDS in the Elderly

Access the Dangers of Non-Steroidal Anti-inflammatory Drugs in the Elderly here:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2280786/pdf/canfamplys00157-0213.pdf>

Care Transitions for Pain

Access the Care Transitions for Pain Implementatin Guide here:

<http://www.scupstateadrc.org/Portals/14/docs/Project%20BOOST%20Implementation%20Guide.pdf>

Answer Key

PAINAD Practice Scenarios

PAINAD Practice 1

0, 1, or 2 (**Correct:** Mr. Frank has relaxed body language, he's not vocalizing, and he's not too restless. Based on those observations, you could rate his pain anywhere from 0 to 2, depending on whether you thought his restlessness was from pain or his dementia.)

3, 4, 5, 6, 7, 8, or 9. (**Incorrect:** Mr. Frank has relaxed body language, he's not vocalizing, and he's not too restless. Based on those observations, you could rate his pain anywhere from 0 to 2, depending on whether you thought his restlessness was from pain or his dementia.)

PAINAD Practice 2

0, 1, 2, 6, 7, 8, or 9 (**Incorrect:** Based on Mr. Frank's body language, vocalization, and restlessness, you could rate his pain anywhere from 3 to 5.)

3, 4, or 5 (**Correct:** Based on Mr. Frank's body language, vocalization, and restlessness, you could rate his pain anywhere from 3 to 5.)

PAINAD Practice 3

0, 1, 2, 3, 4, 5, or 6 (**Incorrect:** Based on Mr. Frank's body language, vocalization, and restlessness, you could rate his pain anywhere from 7 to 9.)

7, 8, or 9 (**Correct:** Based on Mr. Frank's body language, vocalization, and restlessness, you could rate his pain anywhere from 7 to 9.)

Assessing Pain

Quiz Question 1

Which of the following may be an unrecognized factor contributing to behavioral disturbance in older adults?

1. Pain (incorrect)
2. Medication change (incorrect)
3. Urinary retention (incorrect)
4. Constipation (incorrect)
5. All of the selections (correct)

Quiz Question 2

Quiz Question 2: True or false? Using a formalized pain assessment tool for nonverbal adults is better than guessing.

1. True (correct)
2. False (incorrect)

Quiz Question 3

Which of the following is a reasonable tool to use to assess pain in non-verbal adults?

1. The zero to ten pain scale (incorrect)
2. The “mild, moderate, severe” subjective pain scale (incorrect)
3. The PAINAD (correct)
4. The WHO ladder (incorrect)

Decision Point 1

Decision Point 1: What do you feel might be a good first line treatment for Mr. Frank? Choose the colleague with the best answer.

Lily: “Maybe a non-steroidal anti-inflammatory?” (incorrect)

Victor: “I’ve seen a lot of patients here on scheduled Tylenol.” (correct)

Managing Pain

Decision Point 2

Which medication option from your peers’ suggestions seems best to help put Mr. Frank more at ease?

Victor: “We usually see low dose oxycodone or morphine used for older adults with pain that have not responded to Tylenol.” (incorrect)

Malcolm: “A pain patch may be convenient. How about a fentanyl 25 mcg patch?” (incorrect)

Lily: “We could order Norco 10 mg.” (correct)

Quiz Question 1

Quiz Question 1: Which of the following adverse events is NOT commonly associated with the use of nonsteroidal anti-inflammatories in older adults?

1. Renal failure (incorrect)
2. Gastrointestinal bleeding (incorrect)
3. Heart failure (incorrect)
4. Leukocytosis (correct)

Quiz Question 2

Mrs. Wright is a 78-year-old woman experiencing night time pain her bilateral knees, especially on days she spends a long time in the garden. She currently takes no medication. What's a reasonable first step to address her discomfort?

1. Fentanyl patch (incorrect)
2. Low dose methadone (incorrect)
3. Tramadol (incorrect)
4. Acetaminophen (correct)

Quiz Question 3

All of the following are reasonable non-pharmacologic approaches to pain and may be adjunctive pain management strategies except:

1. Massage (incorrect)
2. Mindfulness meditation (incorrect)
3. Surgery (correct)
4. Acupuncture (incorrect)
5. Cold/heat (incorrect)

Evaluating Treatment

What organ does bradycardia and hypotension affect?

- Brain (incorrect)
- Heart, cardiac (correct)
- Histamine release from a mast cell, immune system (incorrect)
- Skeletal, muscle (incorrect)
- Stomach, bowel (incorrect)

What organ does drowsiness, sedation, and hallucinating affect?

- Brain (correct)
- Heart, cardiac (incorrect)
- Histamine release from a mast cell, immune system (incorrect)
- Skeletal, muscle (incorrect)
- Stomach, bowel (incorrect)

What organ does nausea and constipation affect?

- Brain (incorrect)
- Heart, cardiac (incorrect)
- Histamine release from a mast cell, immune system (incorrect)
- Skeletal, muscle (incorrect)
- Stomach, bowel (correct)

What organ does myoclonus affect?

- Brain (incorrect)

- Heart, cardiac (incorrect)
- Histamine release from a mast cell, immune system (incorrect)
- Skeletal, muscle (correct)
- Stomach, bowel (incorrect)

What organ does pruritis affect?

- Brain (incorrect)
- Heart, cardiac (incorrect)
- Histamine release from a mast cell, immune system (correct)
- Skeletal, muscle (incorrect)
- Stomach, bowel (incorrect)

What organ does respiratory depression affect?

- Brain (correct)
- Heart, cardiac (incorrect)
- Histamine release from a mast cell, immune system (incorrect)
- Skeletal, muscle (incorrect)
- Stomach, bowel (incorrect)

Decision Point 3

Your colleagues noticed Mr. Frank is in discomfort and his stomach appears distended.

Choose what you feel to be the best answer to address this situation.

- Victor: *“We can get a bedside bladder scan for residual, even though he’s had wet diapers.”* (incorrect)

- Lily: *“He could be nauseated from the opioids. If we think he still needs them, could we try a different opioid?”* (incorrect)
- Malcolm: *“If he’s constipated, we may want to adjust his bowel regimen. I noticed he’s only on a fiber laxative.”* (correct)

Side Effects

Decision Point 4

Bowel Regimen. Your peers have suggested a number of different options below. Choose the answer you feel is the best solution.

Malcolm: *“Mag Citrate. He’s been here 5 days. It’s time to break out the dynamite.”* (incorrect)

Lily: *“I think I would check him for impaction, maybe try a suppository, and make sure we start him on both a stool softener and a bowel stimulant.”* (correct)

Victor: *“I read about a new medication for opioid induced constipation. Well, actually, it was a commercial on TV, but it seems like it might be applicable here.”* (incorrect)

Quiz Question 1

Potential adverse effects of opioid pain medications include which of the following?

- Constipation (correct)
- Confusion (correct)
- Urinary retention (correct)
- Addiction (correct)
- Respiratory suppression (correct)

Quiz Question 2

True or false? The most appropriate time to provide a bowel regimen is the same time that you provide a prescription for opioid pain medications.

- True (correct)
- False (incorrect)

Quiz Question 3

Quiz Question 3: True or false? Mr. Frank should have a follow-up to his hospitalization to ensure his pain resolved.

- True (correct)
- False (incorrect)