Pain in Residential Aged Care Facilities

Management Strategies

August 2005

The Australian Pain Society
Pain in Residential Aged Care Facilities - Management Strategies outlines good practice principles to assist health care practitioners to successfully identify, assess and manage pain in our residential aged care population.

1. Identification

- Australia’s residential aged care sector needs a pain vigilant culture which appreciates that many residents often suffer from unrecognised pain.
- Failure to identify pain may stem from residents’ cognitive and communicative impairments, social diversity or attitudes. Inadequate staff awareness and high workloads may compound the problem.
- Residents able to report pain should be asked about their pain with genuine concern and carefully phrased questions.
- Two structured procedures, Informant Reports and Staff Observation, should be used to identify pain in residents who are unable to report their pain.
- The possibility of the onset of pain must be considered if there is a significant change in a resident’s condition and, routinely, every three months.

2. Assessment

- Successful pain management is enhanced by the correct diagnosis of the cause(s) of pain because the underlying cause may be remediable and because different types of pain respond to different treatments.
- New acute pain or remediable persistent pain should be diagnosed promptly and treated appropriately.
- Systematic, multidisciplinary collaboration between doctors, nurses, physiotherapists and other care staff is the key to effective pain assessment and management.
- A resident and his or her representative must be informed about, and actively involved in, pain assessment and management.
- Structured procedures must be used to identify the cause(s) of pain, pain intensity and the impact of pain on a resident’s activities of daily living, mood, sleep and quality of life.
- The Resident’s Verbal Brief Pain Inventory (RVBPI) is recommended as a useful standard multidimensional pain assessment tool for residents with sufficient cognitive ability.
The Abbey Pain Scale is recommended as a useful standard pain assessment tool for residents with severe cognitive impairment.

Residents with partial capacity to self-report may benefit from the application of both the RVBPI and Abbey Pain Scale assessments.

Once a comprehensive pain assessment has been completed, uni-dimensional pain assessment tools, such as a Numeric Rating Scale and a Verbal Descriptor Scale, should be used for on-going evaluation of pain intensity and response to treatment.

Multidisciplinary pain management, involving both pharmacological and non-pharmacological approaches, should be routine.

3. Pharmacological Treatments

- Pharmacological treatments require a diagnosis where possible and co-existing medical conditions must be considered.
- Medications should be tailored to the type of pain and its severity.
- Consideration of age-related changes in drug sensitivity, efficacy, metabolism and side effects is essential.
- A pharmacological approach to pain relief must feature an understanding of the mode of action, common side effects and common drug interactions of medications.
- Symptoms other than pain, such as constipation, insomnia and depression, must be treated as part of a resident’s pain management.
- Medication dose, administration, monitoring and adjustment must be carefully considered.
- Paracetamol (1gm 6 hourly) is the drug of choice for musculoskeletal pain.
- NSAIDs and COX 2 inhibitors must be used with caution (short-term, low dose).
- Neuropathic pain should be evaluated and treatment with antidepressant and antiepileptic adjuvant drugs considered.
- Referral to a pain specialist or multidisciplinary pain clinic is an option if troublesome pain persists after reasonable trials of pharmacological and non-pharmacological therapies.
4. Psychological-Educational Approaches

- Cognitive (thought) – behavioural (actions) therapy is supported by strong evidence for the management of persistent pain in older persons and should be made available to all aged care facility residents who might benefit. These are:
  - Cognitively competent residents who are willing and able to try such therapy and who have support from those who care for and interact with them on a day-to-day basis.
  - Those with evidence of pain-related behavioural problems (for example, inactivity, sleeplessness, dependence on others and medication overuse).
  - Those with cognitive or emotional problems related to a persistent pain condition (such as anxiety or depression or those who catastrophise about pain).

- Better coping skills, engagement in social activity and an overall improvement in quality of life are among the benefits of cognitive-behavioural therapy.

- Cognitive-behavioural therapy can reduce self-rated disability, depression, anxiety and mood disturbance, and use of health care resources.

5. Physical Therapies

- Physical therapies can provide pain relief for many aged care facility residents and can have beneficial effects on physical ability and mood.

- Physical therapies selected according to residents’ cognitive, communicative and physical abilities.

- Correctly prescribed and supervised exercise has negligible adverse risk.

- Active resident participation, with adherence to an exercise program, is essential for physical exercise to be beneficial.

- Residents should be informed about the likely benefits of exercise and reassured that initial post-exercise soreness does not usually persist when a program is maintained.

- Isotonic strengthening exercises should be considered for improved pain management in the wide cross section of residents who have diverse functional capacities.

- Aerobic exercise should be considered as a pain management strategy for residents with the physical capacity to improve their cardiac function.

- Physical modalities, such as the application of superficial heat, must be carefully evaluated before use as they are not safe for many residents and are of dubious benefit for chronic pain.

- Transcutaneous Electrical Nerve Stimulation should be considered for the effective management of persistent pain in residents who can provide accurate feedback.

- Manual handling requires a significant level of care and skill.
6. Complementary and Alternative Medicine Therapies

- Complementary and Alternative Medicine (CAM) therapies, such as massage, are mostly used for pain relief in conjunction with orthodox medicine.
- A diversity of therapies may be beneficial if there is good communication between the practitioners and their treatments complement each other.
- More research is needed into the safety and effectiveness of CAM therapies.
- Health care providers must always be informed before a CAM therapy is undertaken. This is for safety reasons (for example, St John's wort interacts with numerous prescribed medications) and to enable the health care team to develop a comprehensive treatment plan based on the needs of each resident.
- Clear approval and consent from the resident, whether cognitively or communicatively impaired, bedridden or fully capable, is essential before a complementary therapy is administered on the recommendation of family, friends, staff or doctors.
- Users should always be fully informed about the safety and effectiveness of any CAM treatment.
- CAM practitioners should be carefully chosen so the resident has confidence in their credentials and qualifications.
- It is advisable to check with private health insurers to see whether a CAM therapy is covered.

7. Quality and Systems Issues

- Successful pain management in the residential aged care sector requires an effective quality enhancement process. The collection of accurate and valid clinical data and the collaborative development of objective clinical indicators would provide a good basis for continuous quality enhancement.
- The residential aged care sector requires organised and integrated multidisciplinary pain management systems. The components of a good system include:
  - An adequately organised and resourced health service infrastructure.
  - A qualified health practitioner in a dedicated pain management co-ordination role within each facility.
  - Access to a network of primary and specialist clinicians.
  - Regular pain management education for staff in aged care facilities.
  - Residents, families and consumers being informed about basic principles of good pain management.
Section 3

Pharmacological Treatments

Pain is often initially treated with medication. However, the evidence base for this approach comes from limited studies, few of which have included residents in aged care facilities.

Good practice principles for pharmacological treatments for pain can be summarised as:

- Make a diagnosis where possible.
- Choose an appropriate drug for the pain type and severity.
- Beware of co-existing medical conditions.
- Use around the clock administration for persistent pain.
- Paracetamol (1gm 6 hourly) is the drug of choice for musculoskeletal pain.
- Use NSAIDs and COX-2 inhibitors with caution (short-term, low dose).
- Anticipate constipation if opioids are prescribed.
- Think of neuropathic pain and consider antidepressant and antiepileptic adjuvant drugs.

NOTE Pain management is often more appropriate and effective when it uses both pharmacological and non-pharmacological approaches.

Key Messages

- Analgesic medications provide symptomatic pain relief. They do not modify the underlying cause of pain.
- Combining pharmacological and non-pharmacological approaches may allow lower drug doses to be used, potentially reducing side effects.
- The selection of medication should be based on the highest likelihood of gaining pain relief with the lowest likelihood of side effects. Consideration must be given to age-related changes in drug sensitivity, efficacy, metabolism and side effects.
- The goal of analgesic therapy needs to be explicit: is the aim to eradicate pain or to reduce it to tolerable levels?

When answering this question, remember:

- Analgesic-induced side effects (for example, constipation, anorexia, nausea, drowsiness, confusion and falls) may be more troublesome than the pain.
- Complete pain relief is rarely achievable when dealing with pain of neuropathic origin.
- Non-cancer pain requires a balance between pain relief and the maintenance of function.
- In the terminal phases of cancer and other end of life situations, the goal may be to relieve pain even if function is compromised.
- The timing of analgesic medications is often as important as the medication selected.
  - A short-acting analgesic should be used for infrequent or incident pain while controlled release analgesics are best given regularly (around the clock) for persistent or frequently recurring pain. Short-acting analgesics may be necessary when controlled release analgesics do not control the pain adequately (breakthrough pain).
  - For predictable or incident pain, analgesics are often more effective when given prior to an activity that is known to induce or aggravate pain, for example, changing a wound dressing or changing position.
- Medications should, generally, be commenced at a low dose, monitored and titrated slowly as required. More frequent monitoring, dose adjustment and higher doses
should be implemented for severe pain as recommended in the Australian Pharmaceutical Advisory Council’s Guidelines for Medication Management in Residential Aged Care Facilities 2002. ¹

- Symptoms other than pain, such as constipation, insomnia and depression, may significantly impact on an individual. Treatment of these is an important part of a resident’s pain management.
- Constipation should be expected with opioid therapy and a bowel regimen (Table 12) routinely instituted.
- Referral to a pain specialist or multidisciplinary pain clinic should be considered if troublesome pain persists after reasonable trials of pharmacological and non-pharmacological therapies.

### TABLE 12

**BOEWEL REGIMEN FOR CONSTIPATION**

- Encourage fluids, especially fruit drinks
- Encourage high fibre cereal, eg bran with adequate fluids
- Keep mobile
- Encourage patient to sit during a bowel movement (using a bedside commode if practical)
- Encourage toileting after meals when gastro colic reflex is maximal
- Provide comfort and privacy

**As well:**

- Exclude treatable causes (hypothyroidism, hypercalcaemia)
- For chronic constipation consider regular bulking agents (ispaghula husk, psyllium) and stool softeners (docusate, liquid paraffin)
- Stimulant laxatives (bisacodyl, senna) are generally recommended for short term use only

Modified from Australian Medicines Handbook 2002² and the American Medical Directors Association Clinical Practice Guideline 1999.³

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**Common Medications**

An understanding of the mode of action, common side effects and common drug interactions is essential when determining a pharmacological approach to pain relief:

**Paracetamol**

Paracetamol is thought to work by inhibiting centrally acting prostaglandins.⁴ It is a common component of many over-the-counter products and combination therapies (for example, paracetamol/codeine combinations and many cold and flu preparations).

Paracetamol is the preferred analgesic for older individuals with musculoskeletal pain and it may be effective for mild forms of neuropathic pain. In most cases, no dose reduction is required for the elderly but care needs to be taken to avoid exceeding the maximum recommended 24-hour limit of 4gm in divided doses (eight standard 500mg tablets) to avoid toxicity. The risk of paracetamol hepatotoxicity is increased by fasting, dehydration, poor nutrition, high alcohol intake or underlying liver dysfunction.

**Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)**

Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) are among the most widely prescribed medications in the world. This group of medications includes conventional NSAIDS and the newer selective cyclo-oxygenase (COX-2) inhibitors. NSAIDs should be used with caution in the elderly and, if prescribed, used in the lowest effective dose for the shortest duration possible. NSAIDs are associated with an increased risk of serious side effects, particularly peptic ulceration and haemorrhage, in this age group. There are theoretical reasons why selective COX-2 inhibitors may cause fewer gastrointestinal complications than conventional NSAIDs but longer term studies are not conclusive.

Both conventional NSAIDs and selective COX-2 inhibitors can cause water and sodium retention, increase blood pressure and peripheral oedema, and reduce glomerular filtration rate. Special caution is required when using these medications in those with hypertension, cardiac failure or renal impairment.
particularly when they are used in combination with Angiotensin Converting Enzyme (ACE) inhibitors. Rofecoxib (Vioxx) has been withdrawn from sale because of adverse thromboembolic events. Other COX-2 inhibitors are being evaluated to ascertain whether they too increase the risk of cardiovascular events.  

Neither the simultaneous administration of two NSAIDs nor surpassing the recommended dose will confer greater pain relief. Low dose corticosteroids may be a safer alternative for individuals with inflammatory arthropathies. Despite concerns regarding the safety profile of conventional and selective NSAIDs in the elderly, in selected cases they are appropriate therapy.  

Selective COX-2 inhibitors and conventional NSAIDs should therefore be used with caution in the older population and for the shortest possible duration to minimise the risk of adverse side effects.

**Tramadol**

Tramadol is an atypical centrally acting analgesic with weak action on some parts of the opioid receptor system. It has significant additional pharmacological actions as an inhibitor of noradrenaline and serotonin reuptake. For this reason it is usually classified separately from the opioid group described below. Short acting (50mg immediate release) and sustained release oral preparations are available. Dose reduction may be required when used in the elderly.

Many patients are unable to tolerate tramadol, experiencing symptoms such as nausea, vomiting, sweating, dizziness, tremors and headaches. Serious side effects include delirium and hallucinations. Serotonergic Syndrome is another possible side effect when other serotonergic medications are used concurrently. These include Selective Serotonin Reuptake Inhibitors (SSRIs), tricyclic antidepressants, venlafaxine and mono-amine oxidase inhibitors such as moclobemide, lithium and St John’s wort. Serotonergic Syndrome features include delirium, confusion, agitation, hypomania, hyperactivity, restlessness, fever, sweating, tachycardia, hypertension, ataxia and tremor. It may occur dramatically or insidiously. Mild forms should resolve within 24 hours of ceasing the medications.

**Opioid Therapy**

Codeine is the mostly widely-used opioid analgesic. It has a short half life and can be recommended for incident, predictable, short lasting and infrequent pain. The usual single dose is 15 - 60mg and it is often given in fixed combination tablets with paracetamol or with aspirin. Codeine can cause constipation, nausea and confusion.

The analgesic effects of codeine can be inhibited by many commonly prescribed medications (for example, cimetidine, quinidine, haloperidol and amitriptyline) and many of the SSRIs including fluoxetine, paroxetine and fluvoxamine.

Codeine does not offer effective pain relief for about eight per cent of Caucasians and two per cent of Asians who lack the necessary processing enzyme. Therefore, it is important to monitor a person’s response to codeine and change to another analgesic if pain relief is inadequate.

Therapy with strong opioid agents such as morphine and oxycodone is well established in the treatment of cancer pain and is also appropriate for selected individuals with severe non-cancer pain.

Older individuals tend to be more sensitive to opioids and experience greater and more prolonged pain relief than younger populations. They are also more prone to side effects. These commonly include constipation (which should be anticipated with a bowel regimen established, Table 12), sedation and cognitive changes (which often settle after a few days) and nausea and itching (which may need antiemetic treatment or, occasionally, drug withdrawal).

Used appropriately, however, controlled release opioids in relatively low doses can provide effective pain relief for older people with persistent pain when non-opioid analgesics have proved inadequate. Patients and/or their representatives should be advised of the likely side effects of opioid therapy to ensure informed consent and appropriate participation in ongoing treatment decisions. Adherence to legal prescribing requirements is essential.
A good principle when using opioid therapy in older individuals is “start low and go slow”. Commence with a low dose, usually of a short acting opioid, assess response, and titrate accordingly until adequate control is achieved. For continuous or frequent pain, sustained release preparations (oxycodone and morphine) are the preferred opioids. Anticipate breakthrough pain, which is usually managed with a dose of a short acting analgesic, often in the order of one sixth of the daily maintenance dose (controlled release morphine 5mg bd; morphine oral liquid 5mg).

Some opioid preparations require additional caution. Fentanyl patches are not appropriate for opioid-naive patients. They should be reserved for patients with high opioid dose requirements who are intolerant of oral preparations or troubled by side effects from other opioids. Pethidine should not be used on a regular basis as its metabolite norpethidine may accumulate causing excitement, agitation, twitching, tremor and convulsions. Older individuals are also more prone to toxicity associated with methadone accumulation due to its variable half life, from six hours up to two to three days.

Phobia regarding the use of opioid therapy often creates a barrier to appropriate pain management. The illicit use of opioids is rarely for pain relief and aberrant opioid seeking behaviours are extremely uncommon in older age groups. This may need to be discussed with the resident and other concerned individuals before they feel comfortable with this form of therapy, particularly for the control of non-cancer pain.

Adjuvant Analgesics

Adjuvant analgesics, such as antidepressants and antiepileptic agents, are valuable in the management of neuropathic pain although they rarely completely eradicate such pain. Reductions in pain severity, even if the pain is not totally eliminated, may still be considered quite valuable by an individual.  

Empirically, antidepressants have been used for neuropathic pain with a burning quality and anticonvulsants used for

CASE STUDY • Neuropathic Pain

Mr K, a 78-year-old hostel resident, complained of troublesome burning pain in his feet, especially at night when it kept him awake. His history included hypertension, diabetes and occasional falls. Mr K was treated with paracetamol at night. His symptoms settled for a while but then recurred, and had been troublesome for three months. His doctor diagnosed painful diabetic neuropathy.

Issues

Diabetic neuropathy and other neuropathic pain, such as post-herpetic neuralgia and central post-stroke pain, tend to be less sensitive to simple analgesic and Non-Steroidal Anti-Inflammatory Drugs than nociceptive pains such as osteoarthritis. However, it is appropriate to try paracetamol and, if this is not effective, a trial of a paracetamol/codeine combination or controlled release tramadol is worthwhile. If pain is unrelieved or side effects become a problem, adjuvant agents such as antidepressants and anticonvulsants should be considered. These have similar efficacy for pain relief in that one in three patients will receive at least 50 per cent more pain relief than with a placebo. The selection of the agent is often based on the side effect profile and cost.

Management

The tricyclic antidepressant amitriptyline was commenced at 10mg at night. Initially this helped Mr K’s insomnia but not his pain. The dose was increased every third day. On 30mg at night he reported less pain on the Resident’s Verbal Brief Pain Inventory (RVBPI) but had difficulty passing urine and was unsteady on his feet due to postural hypotension. The reduced impact of pain on sleep was noted on the RVBPI.

Although amitriptyline has been shown to be effective in managing painful diabetic neuropathy, common side effects may limit its use in older patients. Constipation,
voiding difficulties in males, postural hypotension, falls and excessive sedation are common. The treatment options and costs were discussed with Mr K. Amitriptyline was weaned and gabapentin (100mg at night) was commenced. Sedation and unsteadiness occurred over the first three days but resolved within one week. The dose was slowly increased to 300mg (100mg three times a day). Mr K still had pain at night but considered it quite tolerable. He did not wish to have a further increase in the gabapentin dosage and was maintained on paracetamol (1gm six hourly) and 300mg of gabapentin every 24 hours. A trial of opioid analgesia would have been considered had gabapentin not been effective.

Key Points

- Neuropathic pain such as painful diabetic peripheral neuropathy, post-herpetic neuralgia and central post-stroke pain are less responsive to simple analgesics than are musculoskeletal and other types of nociceptive pain.

- Adjuvant analgesics such as tricyclic antidepressants and anticonvulsants have a specific role in the management of neuropathic pain.

- Adjuvant analgesics rarely eradicate pain but they usually ease it to tolerable levels.

- About one in three patients will experience a 50 per cent pain reduction with tricyclic antidepressants and anti-convulsants. Other patients may report less reduction but will still record a valuable improvement in quality of life.

shooting pains, despite the lack of controlled trial evidence demonstrating efficacy for such symptoms. Selection of adjuvant analgesics should be based on evidence of efficacy for the underlying condition, the side effect profile and availability of the medication.

The older tricyclic antidepressants, namely amitriptyline, nortriptyline, imipramine and desipramine, are commenced in low doses. The analgesic effects are independent of antidepressant effects, occurring more rapidly and at a lower dose than when used for depression. Common side effects include dry mouth, orthostatic hypotension, constipation, urinary retention, cognitive impairment and sedation. However, the sedating effect can be helpful for some residents with pain-related insomnia.

Among the tricyclic antidepressants, nortriptyline may be better tolerated than amitriptyline. The starting dose of these medications is usually 5-10mg at night, increasing gradually, to about 50mg.

Newer antidepressant medications, such as SSRIs, are better tolerated and safer than the older tricyclic antidepressants. However, they have not been shown to be effective for the management of persistent pain.

Anticonvulsants are widely used for neuropathic pain although the evidence of their effectiveness is limited. Carbamazepine is the drug of choice for trigeminal neuralgia. Gabapentin has been shown to be beneficial in the symptomatic management of diabetic neuropathy and post-herpetic neuralgia. As gabapentin is not available for pain management on the Pharmaceutical Benefits Scheme (PBS) in Australia, the cost of this medication is beyond the resources of many.

Other anticonvulsant medications such as carbamazepine, phenytoin and sodium valproate are on the PBS and are worth considering, although evidence of their efficacy has not been conclusively established.
All anticonvulsant medications should be used with caution in frail older individuals. Common side effects include sedation, dizziness and ataxia which predispose the individual to falls. Initial doses should be low (often lower than the approved prescribing information) and titrated slowly as tolerated (carbamazepine 50mg bd; sodium valproate 100mg bd; gabapentin 100mg tds).

In summary, pain of neuropathic origin is often difficult to manage. Combining pharmacological and non-drug therapies is recommended. If simple analgesics do not adequately control the pain, then a trial of a tricyclic antidepressant is worth considering, followed by an anticonvulsant (sodium valproate, gabapentin, carbamazepine), followed by a trial of opioid analgesia, until adequate pain control is achieved.

If the first antidepressant or anticonvulsant is not tolerated at an adequate dose, it is worth considering a different agent within the same class, but the simultaneous use of two medications within one class should be avoided. Because of the variable response to these medications, and the variable severity of their side effects, it is important that each patient is monitored closely and the medication continued only when its therapeutic benefits outweigh the negative side effects.

**Topical Agents**

Topical agents are unlikely to be very effective on their own. However, they may be offered as add-on therapy to reduce the oral medication load.\(^4\) Rubbing or massaging a painful site with over-the-counter or propriety gels or creams is often soothing.

Topical NSAID preparations may give additional pain relief. An extract from hot chili peppers, capsacin, (capsaicin 0.025% and capsaicin 0.075% creams), has some evidence of efficacy in painful diabetic neuropathy and post-herpetic neuralgia. Before treatment residents must be warned of an initial burning sensation upon application and the need to avoid contact with the mouth or eyes. Capsaicin creams are best applied with disposable gloves, followed by hand washing.

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**CASE STUDY • Opioid Therapy in Non-Cancer Pain**

Mrs H is an 88 year old woman who has been a nursing home resident for the past four years. She suffers from a number of problems including moderately severe Alzheimer’s disease, severe osteoarthritis of her knees, profound deafness and visual impairment. Until three months ago, she managed to walk short distances with the aid of a frame. Then she stopped walking and required two nurses to help her to stand. This caused her obvious distress. When sitting she often exhibited spontaneous pain behaviours: crying, rubbing her knees and abnormal vocalisations. She could not verbally communicate her pain experience because of the combination of dementia and deafness. Her pain behaviours at rest and during transfers were recorded on the Abbey Pain Scale.

Her general practitioner had tried her on paracetamol / codeine combinations and tramadol without great success. Anti-inflammatory medications, including COX-2 inhibitors, were not appropriate in view of cardiac failure and renal impairment.

**Issues**

Mrs H had severe pain and disability due to her osteoarthritis. She had not been adequately controlled with standard management and was unsuitable for surgery. Opioid therapy had not been initiated for fear of worsening her confusion.

Age, cognitive impairment and nursing home residence are risk factors for inadequate pain management. Individuals with mild forms of dementia are usually able to communicate their pain experience but this ability is lost with more advanced dementia. Pain is frequently unrecognised or poorly managed in the nursing home setting. Clinicians often have to infer that a person is in pain by observing behaviours and understanding the symptoms associated with the known pathology.
Management

A trial of opioid analgesia, aimed at reducing Mrs H’s pain and optimising her mobility, was commenced. A low dose (5mg daily) of oral morphine mixture (5mls of a 1mg/ml morphine mixture) was introduced three times a day. The dose was titrated upwards twice weekly. Nursing staff observed and charted pain behaviours such as grimacing and vocalisations, ease of bed and chair transfers and confusion levels. They also monitored and managed her constipation. Once tolerating the short acting morphine mixture she was changed to a controlled release preparation, administered twice a day.

By the time the morphine dose had been increased to 15mg 12 hourly, Mrs H appeared to be much more comfortable, with less grimacing and abnormal vocalisations. She no longer required two nurses to transfer her from her bed, being easily managed by one, and was able to take a few steps with assistance. At times she attempted to stand and walk by herself. After analgesia, her Abbey Pain Scale score (with a maximum of 18 and a minimum of 0) reduced from 6 to 0 at rest and 11 to 3 during transfers.

Mrs H was reviewed by a physiotherapist who considered Mrs H’s right knee was too unstable for her to walk unassisted. The dose of morphine was therefore not increased. Twelve months later her pain remained adequately managed with controlled release morphine (20mg 12 hourly).

Key Points

- Age, cognitive impairment and nursing home residence are risk factors for inadequate pain management.
- There is increasing acceptance of maintenance opioid therapy for troublesome persistent pain in older individuals.
- Older individuals are more sensitive to both the analgesic and adverse effects of opioid analgesia.
- Start at a low dose and titrate slowly, according to nursing observations.
- Potential adverse effects of opioid analgesic medications (for example, constipation) should be anticipated and prevented or treated promptly.