2001: Focus on Pain

by Barbara Acello, MS, RN

Pain is an unpleasant sensation associated with actual or potential tissue damage. It is mediated by specific nerve fibers to the brain where its conscious appreciation may be modified by various factors (Stedman's, 1998). Unrelieved pain is a serious problem, with many physical and psychological consequences. Many elderly individuals suffer in silence with pain each day. For many, the pain is not adequately relieved. In fact, a 1990 study showed that 71% of all residents in long term care facilities experienced pain.

Pain greatly interferes with the resident's optimal level of function and self care. It contributes to immobility, increasing the risk of pneumonia, skin breakdown, and many other complications. Chronic pain decreases quality of life, causes hopelessness, and may cause anxiety, depression, and a feeling of helplessness. In confused residents, it causes acting out, crying and other strange, belligerant, or combative behavior. Pain is a major preventable public health issue. In individuals with acute illness, it slows recovery, and increases health care costs.

Text Box 1

Objectives of JCAHO Pain Standards

Under the new pain standards, health care organizations will be expected to:

- recognize the residents' right to regular pain assessment;
- respect and support the residents' right to pain management;
- plan and coordinate activities and resources to assure the pain of all residents is recognized and appropriately addressed;
- assess residents for the presence, nature, and intensity of pain;
- document the results of the pain assessment;
- develop policies and procedures addressing pain medication;
- consider residents' cultural, spiritual, and ethnic beliefs related to pain and pain management;
- teach appropriate staff about pain assessment and management, beginning with facility orientation;
- determine that staff is competent in pain assessment and management;
- educate residents and family members about pain management, and the residents' right to pain relief;
- educate residents and family members about their role in pain management, as well as the potential limitations and side effects of treatment;
- ensure continuity of care in pain management if the resident is transferred to another facility; and
- address the residents' need for pain management in discharge planning and teaching.

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Text Box 2

Overview of JCAHO Pain Standards
• Residents have the right to appropriate assessment and management of pain. • Residents are involved in making care decisions, including managing pain effectively. • Pain is assessed and regularly reassessed in all residents. • Healthcare providers will be educated in pain assessment and management. • Residents will be treated for pain or referred for treatment. • Policies and procedures support safe medication prescribing or ordering, including pain management medications and techniques. • Routine and PRN (as needed) pain medications are administered as needed. • The resident is monitored for pain after potentially painful procedures; • If the resident is medicated for pain, his or her response to treatment is documented. • Residents are taught that pain management is part of treatment. • Residents are taught to understand pain and the importance of effective pain management. • Discharge planning and teaching includes the resident's needs at the time of discharge, including the need for pain management. • The facility collects data to monitor its performance, including the appropriateness and effectiveness of pain management.

Because of the magnitude of the problem, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) has developed standards for pain assessment and management. These standards have been endorsed by the American Pain Society, and must be implemented by all JCAHO accredited organizations. This includes all JCAHO-accredited hospitals, long term care facilities, home health care agencies, behavioral health care facilities, health care networks, outpatient clinics, and health plans. The new pain standards have been phased in over the past year, and became fully effective in January 2001. The new standards aren't really new. Relieving pain has always been part of nursing practice. The "new" standards require facilities to support this essential nursing intervention and ensure that all residents have equal access to pain relief. The objectives of the JCAHO pain standards are listed in text box 1. An overview of requirements is presented in text box 2.

Most long term care facilities are not accredited by the JCAHO, but this is a moot point. Residents have the right to pain assessment and management. Expect your state surveyors to take a closer look at residents with potentially painful

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conditions. When one survey agency focuses on an issue, others follow suit. (*We saw this with restraint reduction several years ago. HCFA led the way and JCAHO followed.*) Surveyors will look at residents to determine if they have been assessed for unrelieved pain. They will also review the facility's pain management techniques and care plans. **In most cases, the nursing assistant is the caregiver who best understands the residents' pain. Since assistants work closely with the residents, they are quickly aware of changes in function, mental status and behavior suggesting the resident is having pain.** Monitor your residents for changes and other hints that they are having pain and promptly report your observations to your nurse manager.

If your long term care facility is JCAHO accredited, your employer has probably developed policies and procedures based on the new pain standards. These will list various methods for teaching residents about pain and will describe techniques for pain assessment and management. Many facilities have also developed pain documentation forms. Most have adopted several different pain scales to evaluate the level of residents' pain. In fact, many facilities now consider **pain the "fifth vital sign."** Under the new standards, if your facility does not have the resources to care for residents in pain, they must refer the resident to another facility or agency who can treat them. Under the JCAHO plan, your employer must provide education for staff in pain assessment and management techniques.

Identify Residents in Pain and at Risk for Pain

Under the new standards, residents have the right to appropriate pain assessment and management. Example pain assessment and management rights are listed in text box 3. These rights are developed by the facility, and are not dictated by the survey agencies. Upon admission to the facility, staff must identify residents who are having pain, as well as those who are at risk for pain. If pain is present, staff must determine the:

* **location** (specific site of pain on the body);
* **duration** (how long the pain lasts)
* **character** (properties, features, characteristics)
* **frequency** (how often it occurs)

Other considerations for pain evaluation are:

pain quality (nature and type of pain);

pain intensity (strength of pain);

radiation, if any (movement of pain to other areas);

variation or **patterns of pain** (changes in pain or cycles of pain);

aggravating and **alleviating factors** (things that improve or worsen the pain);

pain management history, if any (past history of pain and things that make it better or worse);

present **pain management regimen**, if any, and its effectiveness (things the resident does to relieve pain, including medications);

effect of pain upon activities of daily living, sleep, appetite, relationships, emotions, concentration, etc.;

physical assessment and direct observation/ examination of the site of the pain;

side effects of **analgesic** (pain relieving) **medications**, if applicable; and

response to pain medications and other forms of treatment, if applicable.

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Text Box 3

Example Pain Assessment and Management Rights
Residents have the right to expect the health care facility to: • be concerned about pain prevention and management; • include the resident in making care decisions, including decisions about pain management; • provide information about pain and pain relieving methods; • dispel myths about pain, including pain as part of normal aging, addiction, and other common beliefs, as appropriate; • be committed to preventing and relieving pain; • respond quickly to reports of pain; • believe the resident's self report of pain; • consider cultural, spiritual and/or ethnic factors related to pain. • assess and properly manage pain in a timely manner; • provide current and effective pain management techniques; and • modify the plan of care if pain relief is ineffective

The resident's self report of pain is the most accurate indicator of the existence and intensity of pain, and should be respected and believed (McCaffery & Ferrell, 1999). Pain assessment should be simple and frequent. Some facilities may ask residents to complete a pain questionnaire as part of their initial assessment. Pain management should be culturally competent and appropriate to the resident's age and mental status. The results of the pain evaluation should be documented clearly. A flow sheet may be used for this purpose.

Barriers to Effective Pain Management

For a pain program to be effective, all nursing personnel must understand barriers to reporting pain and using medications for pain relief. Encourage residents to report pain. Closely observe residents with conditions that are obviously painful, such as burns, cancer, recent surgery, arthritis, or injuries. If you observe crying, body language, or behavior suggesting pain, monitor the resident closely and report your observations to the nurse.

Dementia is a mental disorder that causes confusion. It is not a disease. Dementia affects the resident's thinking, judgment, memory and ability to reason. **Delirium** is reversible confusion caused by one or more medical problems. Residents with these conditions should be closely observed for pain. In some residents, behavior problems are the only means of communicating pain. If the pain is relieved, the behavior stops. Some residents cry for no apparent reason, and staff assume they are upset or depressed. You may be pleasantly surprised to find that some residents with regular crying or other behavior problems improve dramatically after they are given pain medication!

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Pain management can be challenging in residents from other cultures. Culture may affect the resident's beliefs and outward responses to pain. Some are very dramatic if they are having pain, while others are stoic. Residents from some cultures believe that showing signs of pain indicates weakness. Religious beliefs may also affect the resident's perspective about pain. Sadly, some believe it is a punishment from their higher power, so will not complain. Residents can have pain even if they are smiling, laughing or sleeping, so avoid assuming that residents with these responses are not having pain. A resident may be having pain even if the vital signs are normal. ***If residents complain of pain, believe them!***

Fear of drug addiction is a major barrier to pain management, particularly in the elderly. This fear may also be present in family members and nursing personnel. **Narcophobia** is the irrational fear of prescribing, administering, or using narcotic analgesics (**opioid drugs**) to treat pain. **Opioid analgesics** may also be called **narcotic analgesics**. These are drugs such as morphine, codeine, fentanyl, and opium derivatives. Narcophobia is a problem in both acute and chronic pain, but is more prevalent in caring for residents with chronic pain. Avoid assuming that residents with chronic pain are chemically dependent or addicted. Sadly, many nurses believe that residents who use narcotic (opioid) analgesics for chronic pain are addicted to the drugs. They think they are doing the residents a favor by not administering pain relieving medications. By withholding drugs, they believe they are preventing addiction. *This is a myth with no basis in fact.* In fact, a study done in the early 1990's showed erroneous definitions about pain management, including addiction in many nursing school textbooks (Ferrell et al., 1992)!

According to Brownlee and Schrof (1997), few medical residency programs require doctors to study pain management. Nursing education also lacks focus on pain. Ferrell and her colleagues in 1992 discovered that most nursing programs devoted four clock hours or less to pain management. Inadequate education of these professionals leads to misconceptions in the use of narcotics (Ferrell et al., 1992, Pipp, 1997 "Management of Cancer, 1994"). Additional facts that were uncovered in the review include:

* Nurse researchers found that only one of fourteen nursing texts correctly defined opioid addiction and the incidence of addiction (Ferrell et al., 1992).
* The social stigma surrounding narcotic analgesics is a barrier to pain control. (Gorman, 1997).
* People seeking narcotics for legitimate pain may be viewed suspiciously by physicians, nurses and pharmacists (Pipp, 1997).
* Some family members think narcotic analgesics are illicit drugs (Pipp, 1997).
* 40 percent of cancer patients have undertreated pain. One in four elderly cancer patients in nursing homes receives no treatment at all for daily pain (ABC News, 2000).
* Last year, Oregon's medical board disciplined a doctor for treating a dying cancer patient's pain with Tylenol when a stronger medication was needed. The patient died in pain (ABC News, 2000).
* 9 percent of all Americans suffer chronic pain. Experts say 4 in 10 people with moderate to severe pain don't get adequate relief (ABC News, 2000).

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These facts show that changes in professional education are sorely needed, and will lead to a wider understanding of the differences between drug abuse and the legitimate use of narcotic analgesics (Ferrell et al., 1992).

Individuals with chronic pain may become physically dependent on the drugs and go through some mild withdrawal if the drugs are abruptly discontinued, but this is not the sole indication of addiction. *In fact, less than 1% of all chronic pain patients become addicted to narcotic analgesics.* (Drayer, Henderson, & Reidenberg, 1999; McCaffery & Ferrell, 1999). Many nurses believe the percentage is much higher, particularly if the person has used opioid analgesics for 6 months or more (McCaffery & Ferrell, 1999). **Addiction** is an all consuming, drug seeking behavior. Another condition, called **pseudoaddiction** is often mistaken for addiction. In this condition, pain is partially relieved, but relief is inadequate. These residents may be called "clock watchers." They fear pain, and worry that they will not receive their medication. They watch the clock and request pain medication as soon as it is due. Clock watching behavior stops when pain is adequately controlled.

Tolerance means that a larger dose of the drug is needed to control the pain. Some residents become tolerant after receiving the same drug regularly over a long period of time. Increasing the dose or changing the drug will relieve their pain. This is not a sign of addiction. Pain medications improve the quality of life in residents with chronic pain, but tolerance and dependence are common side effects. *Pain relieving drugs should never be withheld from residents in chronic pain out of fear of causing addiction.* If tolerance develops, the dose can usually be increased as much as 25% to 50% to improve control (McCaffery & Ferrell, 1999; Rhiner, 1999). In fact there is no upper dosage limit to many narcotic analgesic drugs.

Misinformation, misunderstanding, fear, and denial are barriers to effective pain relief. Residents may believe that pain indicates worsening of disease, so deny they are having pain. Some believe taking narcotic analgesics is wrong, even for medical treatment. Some fear sedation and other side effects. Most side effects become less severe over time. Sedation usually subsides in 3 to 4 days. However, ***constipation is a major side effect of opioid drugs that never goes away.*** The nurse assistant must monitor the resident's bowel movements to prevent serious complications, such as fecal impaction. This is a very important responsibility that must not be taken lightly.

Breakdown in the continuity of care is another barrier to effective pain management. Many individuals care for each resident. Residents may be reluctant to discuss their pain with staff members whom they are not comfortable with. They may become frustrated when many people ask the same questions about their pain. Excellent verbal and written communication help promote continuity of care. Other common barriers to effective pain management are listed in text box 4. (Page 24)

Using a Pain Assessment Scale

Since pain is subjective, consistent pain evaluation is a concern. Using a **pain assessment (rating) scale** helps with evaluation and keeps health care providers from forming their own

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Text Box 4

Barriers to Effective Pain Management
• Health care professionals who have inadequate, erroneous or inaccurate knowledge about pain assessment and management; • Inadequate or improper pain assessment; • Assuming the resident is not in pain if he or she is laughing, smiling, or sleeping, or if body language does not display outward signs of pain; • Assuming the resident is not in pain if his or her vital signs are normal; • Poor observational skills; • Poor decision making skills; • Staff fail to utilize pain management resources; • Staff or residents believing myths or misconceptions about opioid analgesics and other drugs given for pain relief; • Staff do not assess residents for pain routinely; • Staff do not believe the residents' self report of pain; • Resident and/or family members reluctant to report pain; • Residents noncompliant with care; • Physicians and nurses reluctant to order/administer narcotic analgesics. Adapted from Hawthorn & Redmond (1998).

opinions about the level of the residents' pain. Using a pain scale prevents subjective opinions, provides consistency, eliminates some barriers to pain management, and gives the resident a means of describing the pain accurately. Your employer should have a variety of pain scales available to meet the needs of the residents. They are an important tool for communication to help the resident *best describe* his or her pain. Pain rating scales can be used to evaluate pain in residents of all ages and cultures. The routine use of pain rating scales is one of the most significant changes brought about by the JCAHO requirements.

The licensed nurse will work with each resident to determine which scale is most effective in helping him or her describe the pain. The resident will select a scale that works the best. If possible, the resident is taught about the pain scale when he or she is not having pain. After the resident understands the pain scale, the nurse will agree with the resident on a pain control goal. All staff will work to achieve this goal. The resident's pain control regimen will be listed on the care plan. Examples pain scales are shown in text box 5.

Although you will not be directly assessing the residents' pain, you must understand the purpose of the scale and how it is interpreted. If the resident tells you that she is having pain at "level 6," for example, you must know what this means and report the problem to the nurse. Likewise, if the resident complains of pain at "level 8" an hour after receiving pain medication, this important finding must also be reported.

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Many **cognitively impaired** (confused) residents can use pain scales (Ferrell, 1996). In my personal clinical practice, I have found the Wong-Baker FACES scale best overall in helping residents describe their pain. It is particularly useful in residents with limited English, aphasia, dementia, and delirium. Many mentally alert residents also prefer the Wong-Baker FACES scale. However, some residents relate to word scales, 0-10 scales, and 0-5 scales. Some residents prefer vertical scales, while others choose horizontal scales to help them describe their pain. As you can see, there is no "one size fits all" pain scale. The selection of a pain scale is a personal decision based on which scale best helps the resident communicate his or her level of pain. This is why facilities must have a variety of pain rating scales available.

When assessing pain with a pain scale, the resident's hearing and vision are a consideration. Many elderly residents cannot see the pictures or numbers. Enlarging the scales on the copy machine may be helpful. Make sure there is adequate light. The resident must be able to see the scale and hear

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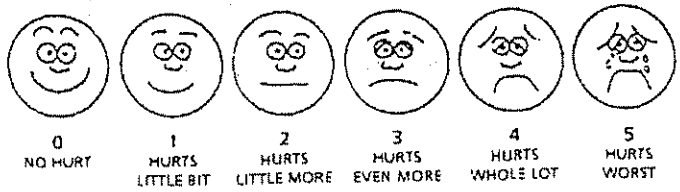
Text Box 5

Example Pain Scales

Wong-Baker FACES Pain Rating Scale



Explain to the resident that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the resident to choose the face that best desribes how he is feeling.

This rating scale is recommended for persons age 3 years and older.

Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the resident to choose the face that best describes his/her own pain and record the appropriate number.

From Wong, D.L., Hockenberry-Eaton, M., Wilson, D., Winkelstein, M.L., Ahmann, E., DiVito-Thomas, P.A.: Whaley and Wong's Nursing Care of Infants and Children, ed. 6, St. Louis, 1999, p. 2040. Copyrighted by Mosby, Inc. Reprinted by permission.

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you. When asking residents about pain, allow enough time for them to process your questions and respond. Frequent teaching and reminders may be necessary at first. Be patient. Residents with cognitive impairment and delirium may surprise you. Avoid assuming that they cannot understand! Many can describe their pain accurately. At the very least, they will admit to having pain if you ask them directly. Unfortunately, many caregivers do not ask confused residents, those who are crying, and those with behavior problems about pain. This is a deficiency in our own education and practice that we must work to correct. As you have seen, unrelieved pain has a devastating effect on quality of life.

Managing Pain

Sometimes the physician orders several different medications for each resident's pain. Selection of which drug to use is done by nursing personnel. Your observations, the resident's self report of pain intensity, and nursing assessment findings are all used to determine which medication to administer, when more than one is ordered. If the first drug does not relieve the pain, the nurse may have the option of administering another, so always report unrelieved pain. *The quality of pain control is notably influenced by the training, expertise, experience, and attitude of the team of health care providers caring for the resident.*

Uncontrolled pain has a profound effect on the resident's health and functional status. Notify the nurse as soon as the resident complains, before pain becomes severe and out of control. Avoid passing judgment about residents receiving pain medication, particularly narcotic analgesics. Opioids are the treatment of choice for acute pain and chronic pain. Some elderly residents tolerate them well, but others do poorly, so observe the resident carefully after pain medications have been given, and report your observations to the nurse. Monitor closely if the resident is receiving a drug for the first time.

In addition to assessment and identifying barriers to pain management, nursing responsibilities and observations for managing pain include:

* determining how the pain affects the resident;
* identifying factors affecting the resident's ability to express pain;
* determining when to administer analgesics;
* deciding which analgesic to administer, if more than one is ordered;
* determining if the medication given relieves the resident's pain; if not, deciding if another medication should be given or if the physician should be notified;
* evaluating the effectiveness of the medication;
* monitoring for and managing side effects of the medication; reporting this information to the physician;
* using basic nursing measures to promote comfort and relieve pain

(Adapted from Redmond, 1998).

Although the nursing assistant is not directly responsible for these things, your observations and nursing care are very important, since you work so closely and intimately with the residents.

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Understanding the responsibilities that health care providers have for pain relief will help you monitor for, and report the appropriate findings to the nurse.

Special Resident Populations

As a group, elderly residents are frequently undermedicated. Many have acute and chronic diseases and multiple medical conditions that cause pain. Delirium and dementia may worsen the problem. Some residents believe that pain is part of normal aging. ***Pain is never normal, and residents should be medicated if they are uncomfortable.*** Residents who have recently undergone surgery and other painful procedures must be monitored closely for pain. Evaluating cognitively impaired residents may be especially difficult because of the resident's inability to describe the problem. Look for behavioral signs and body language suggesting pain. Ask the resident if he or she is having pain. If you suspect a resident is in pain, promptly report your observations to the nurse. Signs and symptoms suggesting pain are listed in text box 6. Always suspect pain if the resident's behavior changes. In residents with mental illness, be aware that mental and behavioral problems cannot be adequately addressed until pain is controlled. Your observation and reporting skills are particularly important with these residents.

Care for residents in long term care is designed to assist residents to achieve optimal function, independence, and quality of life. Obviously, pain decreases quality of life, and can have a devastating effect on the resident's ability to achieve the highest level of function. Monitoring for, developing, and implementing pain relieving measures is important.

Resident Teaching

Nurses are responsible for resident teaching. You may be asked to assist with this teaching, and may be responsible for reinforcing teaching about pain when you work with the resident. Residents should understand that pain management is part of their treatment. Teach the resident on his or her level. If necessary, dispel myths about pain medications and narcotic analgesics.

Comfort Measures

Provide nursing comfort measures to manage pain. Depending on the situation, it may be appropriate to use positioning with pillows, back rubs, a warm bath, cool compresses, or massage. Always follow the care plan, and check with the nurse if you are unsure of what measures to take. Sometimes just allowing the resident to talk about the frustration of chronic pain may be helpful in making her feel better. Always instruct residents to notify you if they are having pain.

Performance Monitoring and Improvement

Performance monitoring and improvement are important in health care facilities. Many excellent resources are available to assist you in understanding and becoming more proficient in pain management. Several are listed in text box 7. Even if you are knowledgeable about pain management, consider reviewing current references. This is an area in which much research is being done, and

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information and care are constantly changing. Develop and expand your observation, reporting, and communication skills. Learn the common side effects of pain medications and closely observe residents for these. Become familiar with various pain scales. Helping alleviate pain and suffering is a major responsibility, and an important part of nursing assistant care. Understanding and adopting JCAHO's commitment to pain will enable you to provide the best care possible for your residents! Pain relief is measured in improved quality of life. By making and reporting observations and assisting residents with pain managment, you will greatly improve their satisfaction, quality of care, and quality of life.

Barbara Acello

Barbara Acello, MS, RN, is an independent consultant in Denton, Texas. She is the Executive Director of Innovations in Heath Care. She has 25 years experience in health care delivery and education both in the public and private sectors. She is the author of numerous textbooks and related projects for nurse assistants, including Infection Control Update, © (Delmar Publishers, Inc., 1996).

Barbara's latest endeavor has been to start an on-line nursing assistant educators group. Members post messages, ask questions, and discusses many of the issues confronting caregivers and their education. As moderator of the group, Barb encourages the helpful responses to any of the group members' needs. To be registered in the group send an email message to Barbara Acello, RN at nursingassistanteducators-owner@egroups.com.

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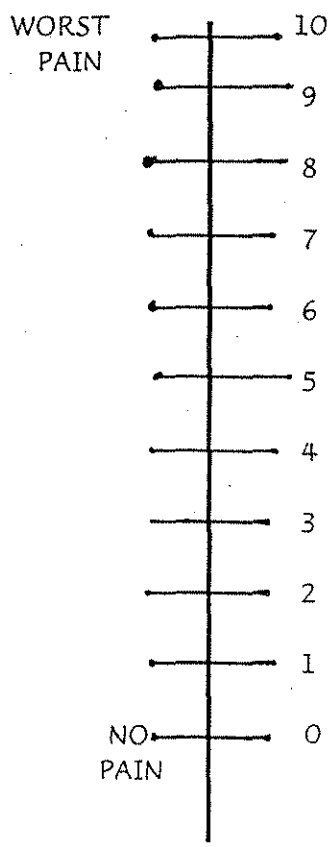
Text Box 5, Continued

Numeric pain scales, in which 0 indicates no pain, and 10 describes severe pain.

Insert numeric pain scales



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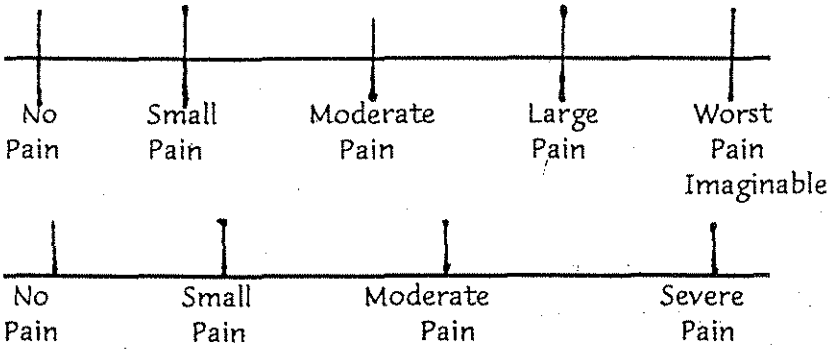
Text Box 5 Continued

Example Verbal Pain Scales



Word Scale#1

SERIOUS PAIN

MODERATE PAIN

LITTLE PAIN

NO PAIN

Word Scale #2

TOO MUCH HURT

A LOT OF HURT

A LITTLE HURT

NO HURT

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Text Box 6

Nonverbal Signs and Symptoms Suggesting Pain

- Moaning
- Grimacing
- Guarded positioning
- Withdrawing to touch
- Restlessness
- Irregular respirations
- Rapid pulse
- Rapid respirations
- Elevated blood pressure
- Intermittent breath holding
- Dilated pupils
- Sweating
- Favoring one extremity
- Irritability
- Withdrawal
- Fatigue
- Anorexia
- Behavior appears opposite of normal.
- A noisy resident becomes quiet.
- A resident who rambles and does not make sense suddenly describes his or her pain.
- A quiet resident becomes belligerent or combative
- An outgoing resident cries or withdraws.
- An active resident is motionless for a long period of time.
- Yelling, screaming, crying for no apparent reason

Focus on Pain – An In-Service

Directions: There is only one correct answer for each question. More than one response per question will be scored as incorrect. Questions left blank without a response will be scored as incorrect. Place the letter preceding your selection on the answer sheet attached to the pre-addressed envelope in the center of this edition. A score of 70% or higher is required for successful completion. Return the answer form and payment of $3.50 for each quiz to the Journal of Nurse Assistants if you want to receive a certificate of completion. This in-service is valued at 1.5 in-service hours for nurse assistants.

Select the one correct answer:

1. Most residents in LTC facilities experience pain.
   A.) True
   B.) False

2. Confused residents who experience chronic pain may be
   A.) very calm and friendly.
   B.) belligerent and combative.
   C.) addicted to pain medications.
   D.) exaggerating when they report their pain.

3. The most accurate indicator of pain is
   A.) blood pressure and temperature.
   B.) pulse and respirations.
   C.) identifying the resident's behavior.
   D.) self reports of pain.

4. A great barrier to pain management is
   A.) addiction.
   B.) misinformation.
   C.) dehydration.
   D.) incontinence.

5. The Baker-Wong (Faces) scale is best used with residents who
   A.) have limited English skills.
   B.) are residents under the age of two.
   C.) have hearing or vision loss.
   D.) have end stage Alzheimer's disease.

6. Nonverbal signs and symptoms of pain are
   A.) low blood pressure and pulse.
   B.) talking quickly while repeating words.
   C.) large appetites.
   D.) fatigue and irritability.

7. Comfort measures include all but
   A.) back rubs using gentle massage.
   B.) turning and positioning for comfort.
   C.) hot shower and sitting up in wheelchair.
   D.) promptly reporting observations to the nurses.

8. "Team Approach" to pain management means that
   A.) pain is to be expected with aging.
   B.) the elderly tend to complain more.
   C.) nurse assistants look for and report to the nurse behavioral signs of pain.
   D.) residents avoid opiates which cause addiction.

9. For a resident who has mental or behavioral problems
   A.) pain is managed first.
   B.) pain is managed after the behavior problems are controlled.
   C.) a diagnosis is made first to properly prescribe medications.
   D.) the symptoms are treated with psycho-therapy.

10. Nurse assistants primary roles include all but
    A.) teaching the resident to report pain.
    B.) observing pain intensity.
    C.) using basic nursing to provide comfort.
    D.) deciding which analgesic works best.