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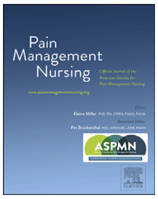

Original Article

An Exploration of Pain Documentation for People Living with Dementia in Aged Care Services

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ABSTRACT

Background: Pain in people with dementia is a common occurrence. Providing evidence-based pain management for people with dementia in residential aged care services is imperative to providing quality care. However, it remains unclear from current research how various aged care staff (Registered Nurses (RNs), Enrolled Nurses (ENs), Personal Care Assistants (PCAs)) engage at specific points of the pain management pathway. With structural changes to the residential aged care workforce over the past two decades, understanding the relative contributions of these aged care staff to pain management practices is crucial for future practice development.
Aim: To investigate the quality and completeness of pain documentation for people living with dementia, and assess the extent to aged care staff are engaged in documentation processes.
Design: A three-month retrospective documentation audit.
Setting and Participants: The audit was conducted on the files of 114 residents with moderate to very severe dementia, across four Australian residential aged care facilities.
Methods: Data was collected on each resident's pain profile (n=114). One hundred and sixty-nine (169) pain episodes were audited for quality and completeness of pain documentation and the extent to which aged care staff (RNs/ENs and PCAs) were engaged in the documentation of pain management.
Results: Twenty-nine percent of pain episodes had no documentation about how resident pain was identified and only 22% of the episodes contained an evidence-based (E-B) assessment. At least one intervention was documented for 89% of the pain episodes, the majority (68%) being non-pharmacological. Only 8% of pain episodes had an E-B evaluation reported. Thirteen percent (13%) of episodes contained information across all four pain management domains (Identification/ problems, assessment, intervention and evaluation). Documentation by PCAs was evident at all points in the pain management pathway. PCAs were responsible for considerately more episodes of assessment (50% vs 18%) compared to nursing staff.
Conclusion and Clinical Implications: Despite the high prevalence of pain in people with dementia in aged care settings, current pain management documentation does not reflect best practice standards. Future capacity building initiatives must engage PCAs, as key stakeholders in pain management, with support and clinical leadership of nursing staff.

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Adequately responding to pain experienced by people living with dementia in residential aged care (RAC) settings (also referred to as care homes, long-term care setting, or nursing homes) (Corbett et al., 2012) is a care imperative. Pain is largely caused by age-related musculoskeletal conditions and is estimated to be present in at least 50% of people living with dementia in long-term care settings (Corbett et al., 2012; Herr, 2010). The overall prevalence of pain in these settings is variable across international data, ranging from 60% to 80% (Corbett et al., 2012; Takai, Yamamoto-Mitani, Okamoto, Koyama, & Honda, 2010). Pain assessment for people with dementia is challenging especially in the later stages of the disease process as cognitive and linguistic skills diminish. With increasing cognitive impairment the ability to self-report pain is compromised and people often have behavioral changes associated with pain. Assessment is then based on behavioral-observational tools (Hadjistavropoulos, Herr, et al., 2014). However, behavioral changes are often attributed to psychological or psychiatric problems rather than pain, resulting in misdiagnosis and underassessment (McAuliffe, Nay, O'Donnell, & Fetherstonhaugh, 2009). The consequences of untreated pain include impaired physical function and falls (Corbett et al., 2012), depression (Landi et al., 2005), anxiety (Sampson et al., 2015), behavioral and psychological symptoms of dementia such as agitation and aggression (Malara et al., 2016), and an overall reduction in quality of life (Corbett et al., 2012).

Despite the development of a range of best practice pain management guidelines and resources (American Geriatrics Society, 2002; Australian Pain Society, 2005; Goucke et al., 2007; Hadjistavropoulos et al., 2007), current research suggests that the translation of this evidence into practice has been, at best, variable in aged care settings (Sacoco & Ishikawa, 2014; Savvas, Toye, Beattie, & Gibson, 2014a). In recognition of this evidence-practice gap, a number of studies have implemented programs to improve staff knowledge of best practice recommendations, as well as implementing pain management protocols to enhance staff engagement in pain assessment and management practices (Hadjistavropoulos, Herr et al., 2014; Horner, Hanson, Wood, Silver, & Reynolds, 2005; Liu & Lai, 2017; Savvas et al., 2014a; Savvas, Toye, Beattie, & Gibson, 2014b). However, outcomes have been mixed. For example, one study implemented an observational pain management protocol that had a positive outcome on the frequency and type of nonpharmacologic interventions used but no effect on the use of pain medications (Liu & Lai, 2017). Another study found improvement in pain assessment but did not identify a difference in pain treatment (Horner, Hanson, Wood, Silver, & Reynolds, 2005). Likewise, the frequency of pain assessment was also increased in a study by Hadjistavropoulos, Kaasalainen, Williams, & Zacharias (2014) but with no effect on the percentage of residents in moderate to severe pain. In work by Savvas et al. (2014a), a multifaceted implementation program produced modest improvement toward full compliance with best practice standards.

Key challenges to best-practice management of pain in older people with dementia include limited use of pain assessment tools by clinical staff and lack of capability and confidence among aged care staff to interpret pain cues and to initiate treatment (Achterberg et al., 2013; Gilmore-Bykovskyi & Bowers, 2013; Holloway & McConigley, 2009; McAuliffe, Nay, O'Donnell, & Fetherstonhaugh, 2009; Peisah, Weaver, Wong, & Strukovski, 2014). Although research suggests that at least some of these issues can be addressed through targeted education (Achterberg et al., 2013; Kaasalainen et al., 2007; Savvas et al., 2014a), broader systemic issues contribute to poor compliance with best practice and necessitate more comprehensive approaches than education alone. For example, structural changes in the composition of the Australian aged care workforce, such as the expansion of the role of personal care assistants (PCAs; also referred to as care workers, health care assistants, nursing assistants, and assistants in nursing) into areas of pain recognition, assessment, and some treatment practices (Corbett et al., 2016; Holloway & McConigley, 2009) along with a sector-wide decrease in the numbers of clinical nursing staff (registered nurses [RNs] and enrolled nurses [ENs]) (Mavromaras et al., 2017) present challenges for evidence-based practice. Additionally, a lack of clinical leadership by nursing staff to support PCAs' engagement in pain management processes (Corbett et al., 2016; Jansen et al., 2017) and ineffective communication and support networks to assist in operationalizing the expanded role of PCAs have been identified as key barriers to the delivery of best practice in pain management (Corbett et al., 2016; Holloway & McConigley, 2009; Peisah et al., 2014).

Given the aforementioned workforce changes, it remains unclear from current research the extent to which various aged care staff (PCAs, ENs, and RNs) engage in pain management practices and at which specific points in the pain management pathway they are engaged. It is imperative to understand the relative contributions of aged care staff in the current pain management landscape because this will provide important data for future practice development and improvement. Therefore, in the context of a participatory action research study that aimed to better support aged care staff to engage in evidence-based pain management practice, we conducted an audit of documentation, as a precursor to planning and taking action. This paper reports the results of the documentation audit, which assessed the quality and completeness of pain-related documentation and the engagement of aged care staff in the documentation process.

Methods

Study Design

This study was conducted in four RAC services, located in two states of Australia (New South Wales and Victoria). In each state, two services were recruited (one metropolitan and one regional or rural). All the services provided care for people living with dementia, with variations in size and bed allocation. RAC facilities (RACFs) A and C were metropolitan services and contained between 80 and 90 beds. RACF A was an entirely dementia-specific service provider, and RACF C had integrated care. RACF B was a regional service and RACF D was rural. Both comprised approximately 60 beds. RACF B had a 20-bed dementia-specific unit and RACF D contained a 10-bed dementia-specific unit.

The study design was based on a participatory action research approach, with mixed methods of data collection. At each site an action group of staff members interested in improving pain management practices was established. Before engaging group members in recurring action cycles of problem identification, planning action, taking action, data collection, analysis and reflection, and replanning, a “reconnaissance” (Kemmis & McTaggart, 1988) of key issues was conducted. This comprised baseline data collection aimed at understanding current pain management at the services and the extent to which this reflected best practice approaches. This baseline data included (a) staff and family surveys, (b) resident documentation audit, and (c) staff and family interviews. From these data, the action groups could identify evidence-practice gaps, formulate problems, and move through action cycles. In this paper we present the findings from the resident documentation audit. The study was approved by the University of New South Wales, HREC (HC16960).

Data Collection

The resident documentation audit collected data on the quality and completeness of pain-related documentation. Pain-related documentation was any entry that was made in the residents' nursing or medical documentation that made reference to resident pain or discomfort, or an assessment for pain or discomfort, or the use of the use of pain-relieving interventions (pharmacologic or nonpharmacologic). Hence, pain episodes were only recorded when there was a clear indication that pain was considered either as a cause or evident through an assessment or choice of intervention. Pain-related documentation was audited across domains of identification, assessment, treatment, evaluation, and monitoring. Resident inclusion criteria for the audit were as follows:

- A formal diagnosis of dementia by medical practitioner *or*
- Documented suspected dementia or cognitive impairment in care notes with a Psychogeriatric Assessment Scale score of 4 or greater *or*
- Documentation by a clinical staff member indicating that a Psychogeriatric Assessment Scale could not be undertaken because of severe cognitive impairment *and*
- Permanent resident of the service for a minimum of 3 months.

The audit tool was developed for the project by members of the project team who had expertise in pain medicine (PS), aged and dementia care nursing (SA), and audit development (SA). Early drafts of the audit tool were piloted (SA and RT) and further refined. Data were collected, and during the early stages of collection, a random selection of 10 resident files were double audited to ensure consistency of data extraction and interrater reliability. The audit tool comprised three sections described in Table 1.

Data Analysis

Exploratory, descriptive analyses were conducted. Frequencies were calculated for all categorical data. For resident demographic and pain profile data (section 1 of the audit), the mean and standard deviation are presented for normally distributed continuous data (resident age and total number of medical diagnoses). The median and interquartile range have been provided for skewed data (i.e., length of stay and number of pain episodes over the 3-month audit period). When analyzing the quality of pain documentation (section 3 of the audit tool), pain assessment and evaluations of interventions were classified as either evidence based (E-B) or non—evidence based (non-E-B) for the purposes of analysis and reporting. The E-B assessments and evaluations reflected the use of tools or processes that are considered to be reliable, valid, and reflective of best practice, according to the Australian Pain Society (2005) guidelines.

The percentage of staff who documented across the various points of the pain pathway was calculated across three groupings—RN/EN, PCA, and other. In the "other" category, staff such as occupational therapists, physiotherapists, general practitioners, and leisure and lifestyle staff were collapsed together because the numbers of these individual staff were too small to warrant their own groupings.

The analysis of documentation completeness was developed by creating four additional audit variables for which frequencies were calculated. These were as follows:

Variable 1: The proportion of episodes where the problem/identification, E-B assessment, intervention and E-B evaluation were ALL documented.

Variable 2: The proportion of episodes where the problem/identification and intervention ONLY were documented.

Variable 3: The proportion of episodes where the problem, intervention, and evaluation ONLY were documented.

Variable 4: The proportion of episodes where E-B assessment and intervention ONLY were documented.

All analysis was performed using Stata Version 15.1 statistical software.

Results

A total of 114 resident files were audited, which accounts for 80% of eligible residents across the four services. From the audit of 114 resident files across four RAC services, our sample comprised largely female residents, had an average age of 86 years, with moderate/severe cognitive impairment, and a median length of stay just less than 3 years. Table 2 outlines the participant demographic characteristics and pain profiles. Across the 3-month audit period the median number of pain episodes per resident was 12 (interquartile range, 1-21) and overall, 86% of residents had at least one documented pain episode during that period.

Quality of Pain Documentation

Pain Identification

Table 3 presents the major audit findings of 169 pain episodes across the four RAC services. Just under one third of episodes had no documentation related to how staff identified that a person with dementia was in pain. For example, these entries would state that

Table 1
Audit Tool Domains, Data Collected, and Documentation Sources

Sections of Audit Tool	Information Collected	Documentation Sources
Section One: Resident demographic information and pain profile	Age, gender, length of stay, medical diagnoses, presence of pain, pain type and duration, cognitive impairment (PAS score)	Admission profile, medical diagnoses list, care plan, care and nursing notes, and medical notes
Section Two: Total number of pain episodes documented during audit period	Each pain episode listed and numbered, date of episode recorded	Care and nursing notes, medical notes, pain assessment forms
Section Three: Quality of pain episode documentation	Two (2) pain episodes[*] randomly chosen (using a random number generator) from those episodes listed in section two of the audit; detailed information collected from each pain episode about how pain was identified, assessed, treated (pharmacologically[†] and nonpharmacologically), and evaluated Which staff were responsible for the various documentation	Care and nursing notes, medical notes, pain assessment forms, medication charts

PAS = Psychogeriatric Assessment Scale.

[*] A pain episode was defined as any entry that contained reference to resident pain or discomfort and any associated documentation related to assessment, intervention, and evaluation. Hence, one pain episode could comprise a number of separate entries.

[†] Analgesics were coded consistent with the Anatomical Therapeutic Chemical classification system (WHO Collaborating Centre for Drug Statistics Methodology).

Table 2
Resident Demographic Information and Pain Profile (N = 114)

Demographic Characteristics	n (%)
Male	32 (28.1%)
Female	82 (71.9%)
Age (mean, SD)	86.2 (8.1)
PAS score	
Moderate impairment (PAS 4-9)	7 (6%)
Severe impairment (PAS 10-15)	54 (47%)
Very severe impairment (PAS 16-21)	29 (25%)
PAS not done because of severe cognitive impairment	21 (18%)
No PAS—missing	3 (3%)
Length of stay (in weeks) (median, IQR)	150 (88, 319)
Resident Pain Status	
Total no. of medical diagnoses (mean, SD)	4.2 (1.2)
Identified as having chronic pain/a chronic painful condition	107 (95%)
Chronic painful condition and multidimensional pain assessment within last 12 months	35 (31%)
Resident has been affected by any pain in the 3-month audit period	95 (86%)
Pain duration	
Less than 3 months	13 (14%)
More than 3 months	57 (59%)
Both	26 (27%)
Total number of pain episodes in the 3-month audit period (median, IQR)	12.0 (1.0, 21.0)

SD = standard deviation; PAS = Psychogeriatric Assessment Scale; IQR = interquartile range.

Table 3
Quality of Pain Documentation (N = 169)

Pain Episodes Audited	n (%)
Identification of pain	120 (71%)
Behavior change observed	27 (23%)
Unspecified (e.g., “general discomfort”)	42 (35%)
Resident self-report	19 (16%)
Site of pain specified only	10 (8%)
Change in physical health observed by staff	7 (6%)
Change observed by family member	1 (1%)
Resident response to staff asking about pain	2 (2%)
Other (e.g., concern raised by allied health staff)	11 (9%)
No pain identification documentation	49 (29%)
E-B assessment of pain[*]	38 (22%)
Abbey Pain Scale	26 (68%)
PAINAD Scale	2 (5%)
Resident self-report (qualitative)	1 (3%)
Resident self-report (unidimensional rating)	7 (18%)
Qualitative documentation by staff	1 (3%)
Medical review of the resident	1 (3%)
Non−E-B assessment of pain: staff rating on 0-5 scale	70 (41%)
No pain assessment documented	61 (36%)
Pain intervention	144 (85%)
Pharmacologic intervention	41 (28%)
Nonpharmacologic intervention	96 (67%)
Both pharmacologic and nonpharmacologic	7 (5%)
No pain intervention documented	25 (11%)
E-B evaluation of the intervention	10 (6%)
Formal assessment tool (Abbey, PAINAD)	2 (2%)
Resident self-report[†]	8 (8%)
Non−E-B evaluation of pain	118 (70%)
Qualitative feedback[‡]	47 (36%)
Staff rating on 0-5 scale[§]	71 (55%)
No evaluation documented	41 (24%)

PAS = Psychogeriatric Assessment Scale; PAINAD = Pain Assessment in Advanced Dementia.

[*] Pain assessment and evaluations of interventions were classified as either evidence based (E-B) or non−evidence based (non-E-B) according to the Australian Pain Society (2005).

[†] Either qualitative feedback or unidimensional rating.

[‡] *Qualitative feedback* refers to staff documentation, such as “pain improved” or “good effect.”

[§] *Non−E-B assessment* refers to the use of a 0-5 scale. This rating was only based on staff's subjective interpretation and was not based on any formal assessment process.

the resident was “in pain,” with no further explanation as to how this decision was arrived at. Of the 71% of episodes that did contain such documentation, 35% of these entries were nonspecific descriptions such as “general discomfort” and “looks uncomfortable.” In slightly more than 20% of episodes, some type of behavior change was documented as a possible indication of pain. Only 16% of entries referred to a resident's verbal report of pain, and 2% indicated that the resident had been explicitly asked about the presence of pain. Only one entry referred to feedback from a resident's family member that related to pain identification.

Overall, 33% of the pain identification entries were documented by PCAs and the same proportion by RN/ENs, whereas 11% were documented by other staff (who included allied health staff [8%] and one general practitioner). However, in 24% of episodes, the staff member who completed the documentation either could not be identified or was not specified.

Assessment

Overall, less than a quarter (22%) of the episodes contained E-B assessment information. Of these entries, the Abbey Pain Scale (Abbey et al., 2004) was predominantly used (68% of audited pain episodes). A total of 50% of the entries were documented by PCAs, compared with 18% by RN/ENs and 25% by “other” staff (comprising an occupational therapist, a general practitioner, and lifestyle and leisure staff).

Intervention

At least one intervention was documented for 85% of the pain episodes. The majority of these interventions were nonpharmacologic (67%) (e.g., heat packs, massage, diversion, and repositioning). Moreover, in some instances, two or three nonpharmacologic approaches could have been used in combination. For the pharmacologic interventions (28%), the majority (69%) of medications (e.g., simple analgesic, opioid, nonsteroidal anti-inflammatory) were administered on an as-needed (PRN) basis. Overall, 24% of the entries related to either nonpharmacologic or pharmacologic interventions were made by RN/ENs, 27% by PCAs, and 9% by other staff. In 40% of episodes, the staff member who completed the documentation either could not be identified or was not specified.

Evaluation

Only 8% of pain episodes that had an intervention documented also had an E-B evaluation reported. A total of 24% had no evaluation at all and 70% of episodes had non-E-B evaluations of the intervention effectiveness. These non-E-B evaluations included qualitative comments related to an intervention such as “with good effect” or “with some effect”; and at RACF A, the 0-5 staff rating scale (referred to earlier) was predominantly used. The proportions of staff documenting the evaluations (either E-B or non−E-B) were RN/EN 21%, PCAs 26%, other 9%, and 45% not specified.

Completeness of Pain Documentation

The completeness of pain-related documentation was also audited. As demonstrated in Table 4, only 13% of pain episodes contained information across all four pain documentation domains (identification/problems, E-B assessment, intervention, and E-B evaluation). Most episodes (83%) contained only documentation about the problem and the intervention.

Table 4
Completeness of Pain Documentation (N = 169)

Completeness of Pain Documentation	n (%)
Proportion of episodes where problem, assessment, intervention, and evaluation were all documented	22 (13%)
Proportion of episodes where ONLY problem and intervention were documented (i.e., no assessment or evaluation documented)	141 (83%)
Proportion of episodes where ONLY problem, intervention, and evaluation were documented (i.e., no formal assessment done)	130 (77%)
Proportion of episodes where ONLY assessment and intervention were documented (i.e., no evaluation)	23 (14%)

Discussion

To our knowledge, this is the first paper that has investigated the quality and completeness of pain-related documentation and the extent to which different staff groups documented resident pain at the various points of the pain management pathway in RAC settings. The sample in this study is strongly representative of those living in Australian RAC facilities (Australian Institute of Health and Welfare, 2011, 2012).

Consistent with previous research (Sandvik et al., 2014), a very high percentage of our sample had a diagnosis of chronic pain or a chronic painful condition (95%) and experienced at least one documented pain episode (86%) during the audit period. However, despite this pain profile, only one third (31%) of residents had a multidimensional/comprehensive pain assessment completed in the prior 12 months. Our findings support earlier work indicating poor compliance in performing comprehensive pain assessments in aged care facilities (Sacoco & Ishikawa, 2014). When conducted regularly or in response to pain or a change in the resident condition (Goucke et al., 2007), assessments are critical to the identification of causes and characteristics of the pain, as well as the overall impact on the person and their quality of life (Australian Pain Society, 2005). Without comprehensive assessment occurring as part of routine practice, the extent to which an individual's pain history is understood by nursing and care staff and used to guide the management process is at best marginal.

Analysis of the quality of documentation for each pain episode revealed that, overall, documentation also did not meet best practice standards (Australian Pain Society, 2005; Goucke et al., 2007). With regard to pain identification, in 16% of audited episodes pain was identified by resident self-report, and in only 2% of episodes did the documentation indicate that residents had been asked by a staff member whether they were experiencing pain. Self-report is considered gold standard for pain identification for people with and without cognitive impairment (American Geriatrics Society, 2002; Australian Pain Society, 2005; Lukas, Barber, Johnson, & Gibson, 2013). In our study the lack of verbal reporting may have been due to the significant level of cognitive impairment (Table 2). However, it may also reflect previously reported staff uncertainty about the utility of self-report as an identification mechanism (Gilmore-Bykovskyi & Bowers, 2013).

A lack of specificity about the presentation of pain (e.g., “general discomfort” and “uncomfortable”) in more than one third of pain episodes raises concerns about the ability of staff to recognize individual indictors of pain. With at least one third of pain identification entries made by PCAs (compared with 11% by RN/ENs), the poor quality of documentation may reflect the difficulty staff have in delineating between pain and other behaviors of distress in people with dementia (Gilmore-Bykovskyi & Bowers, 2013; Tousignant-Laflamme et al., 2012). Earlier research highlights the need for processes that support staff capability (in particular PCAs, given their position as “frontline” staff) to develop and document comprehensive understandings of each individual resident's pain story (Peisah et al., 2014). Moreover, systematic assessment protocols have been reported to assist staff in discriminating pain from other causes of distress (Hadjistavropoulos, Kaasalainen, et al., 2014). Indeed this approach would be beneficial given that another 23% of episodes in our audit referred to some type of observed change in a resident's behavior. Arguably such observations require in-depth knowledge of the person's pain story and how it changes over time.

Consistent with earlier work (Sacoco & Ishikawa, 2014; Torvik, Nordtug, Brenne, & Rognstad, 2015), our findings indicate a distinct lack of documented pain assessments using validated tools. Only 22% of pain episodes in our study reported the use of a standardized and validated tool (in most cases, the Abbey Pain Scale [2004]). Given the lack of rigorous assessment practices, it is imperative that efforts be concentrated on the implementation of evidence-informed protocols and associated education/training, which have been found to support staff to be “more deliberate” and systematic about assessing pain (Hadjistavropoulos, Kaasalainen, et al., 2014, p. 755). Moreover, given that 50% of assessment documentation was undertaken by PCAs, our findings underscore an urgent need to support these staff to effectively engage in robust pain identification and assessment processes. RN/ENs were found to be responsible for only 18% of assessment entries, raising concerns about the level of engagement these staff have in assessment practices. Arguably, this data set reflects the expanding role of PCAs into what have previously been areas of RN/EN practice. Holloway and McConigley (2009) highlight that with this role expansion there have been inadequate efforts to redefine the PCA scope of practice or provide educational preparation relevant to these extended boundaries. The limited use of E-B pain assessments by PCAs reflects a key capability issue that needs to be addressed.

In terms of pain intervention/treatment, the majority of pain episodes (87%) had either a nonpharmacologic or pharmacologic intervention documented, which is encouraging. Pharmacologic interventions, which accounted for marginally more than one third of treatments, were administered as PRN medications. Given the severity of cognitive impairment in our sample, this dependence on PRN medications as the mainstay of pharmacologic management is problematic. People with dementia are less likely to be given analgesic medications (Herr, Bjoro, & Decker, 2006; Morrison & Siu, 2000), hence the prescription of regular scheduled analgesia is recommended for optimal management of chronic pain (Hadjistavropoulos et al., 2007). Nonpharmacologic strategies accounted for more than two thirds of interventions. It is possible that the frequent use of nonpharmacologic interventions reflects the growing evidence to support the use of these strategies as key components of effective pain management (Ellis, Wells, & Ong, 2017). However, it is likely that staff beliefs around pain severity, misconceptions about analgesic administration, or the propensity of staff to choose familiar nonpharmacologic interventions (Liu & Lai, 2017) may also explain this finding.

Despite the high prevalence of pain interventions in our study, E-B evaluation of these interventions was found to be extremely low. Given the low frequency of E-B pain assessment after pain was identified (as discussed earlier), it is perhaps not surprising that E-B evaluation was not prioritized. The reliance on brief qualitative comments such as “with effect” or “with some effect” or staff reported subjective pain ratings further reflects ad hoc approaches to management. The fact that in 45% of pain episodes there was no clear indication of which staff had provided the documentation further demonstrates a lack of attention to the importance of evaluation and follow-up.

Finally, it is concerning that only 13% of pain episodes contained documentation across all points of the pain pathway (i.e., identification, assessment, intervention, and evaluation). This finding adds further weight to our contention that current pain management practice lacks a systematic approach. It also raises serious concerns about the quality of current pain care and the current capacity of clinical leaders (e.g., RNs or ENs) and care staff to be responsive to pain experienced by people living with dementia in RAC settings.

Implications for Practice

Overall the findings of this study suggest an urgent need for radical changes in how pain is managed in aged care services. This requires more than just shifting from the benign recognition that pain is present in older people living with dementia to a more proactive and nuanced stance that encompasses all nursing and care staff. In addition to clinicians (RNs and ENs), the involvement of PCAs is imperative given that their role extends across the boundaries of hands-on care to include proxy clinical work such as pain identification, assessment, and intervention-related practices. Based on the findings of this study, we agree with the opinions of others (Corbett et al., 2016; Dobbs, Baker, Carrion, Vongxaiburana, & Hyer, 2014; Ersek & Jansen, 2014) that PCAs must be supported proactively by clinical leaders/nursing staff to engage in pain assessment and management processes. Without the contributions of PCAs being heard and valued, their engagement in pain reporting and management processes is at risk of being perfunctory and ambiguous (Jansen et al., 2017).

This study contains a number of limitations. First, we collected data from paper-based and online resident records. Between the four different services, documentation sources and the various locations of documentation varied greatly. Despite our best efforts to ensure accuracy and consistency of collection, there is a risk that some episodes of pain may not have been captured. Moreover, the audit tool was not designed to discern when documentation of resident behavior suggested pain (i.e., increased agitation, aggression, or withdrawal). Given that behavioral changes can signify pain (Pieper et al., 2018), but may not necessarily be recognized by staff (Burns & McIlfatrick, 2015), it is likely that the number of pain episodes could have been underestimated in this study.

Conclusions

This study makes a valuable contribution to the literature by highlighting the discrepancies in the completeness and consistency of the application of E-B approaches to pain management for people living with dementia in RAC settings. The engagement of PCAs in the pain management pathway has not previously received concerted attention in the research literature. Our findings address this gap and emphasize that these staff are key stakeholders in pain management processes and that if best practice is to be routinely adopted in RAC services, these staff members must be at the center of implementation and improvement efforts, supported proactively and collaboratively by nursing staff.

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