

Resident-Centered Pain Care: Creating & Sustaining Practice Changes

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Accomplishments so far?

- Evaluated policies and developed new ones
 - Screening
 - Assessment & reassessment
 - Developing a plan of care
 - Evaluating the response
- Evaluated clinically relevant performance improvement measures
- Educated staff
- Educated residents

Why is it so hard ?



- Scores improved but now are getting worse
- Old practice sneaking back
- Others do not perceive the need to address pain over time
- Pain is easy to make invisible



Best Practices for Pain Assessment & Management

- Person with pain is the expert
- Systematic and ongoing assessment is key
- Combine medications with nondrug interventions in an order that manages pain effectively
- Adjust medications to individual response
- Perform ongoing evaluation of the effect of interventions
- Communicate the plan to others
- Identify and deal with barriers
- Continue to improve



Best Practices

All pain management is based on individual response

Best Practices: References

- American Pain Society
 - Use of analgesics
 - Cancer pain
 - Arthritis pain
 - Sickle cell disease pain
 - Fibromyalgia
 - www.ampainsoc.org
- American Geriatrics Society
 - Persistent pain in older people
 - www.americangeriatrics.org
- American Medical Society
 - Teaching modules
 - www.ama.org
- American Society for Pain Management Nursing
 - Core curriculum
 - www.aspmn.org
- Agency for Health Care Research & Quality
 - Acute pain
- American Medical Directors Assoc.
 - www.amda.com



A Facility-wide Approach to Pain Management

- Assess and reassess your pain management program
- Develop an interdisciplinary team
- Articulate a standard of care
- Assess policies and procedures
- Educate staff
- Educate residents
- Continuously monitor and improve



Best Practices: Pain Policies & Procedures

- Written standard of care
- Screening @ predetermined intervals
 - Standard tool
 - Minimum required frequency
 - ✓ On admission, every visit/shift
- Process for assessment
 - Standard tool
 - Cognitively intact & impaired
 - Standard for frequency & re-assessment
 - Each shift (or other designated frequency)
 - New pain, unrelieved pain, procedures, transitions etc.
- Process for intervention
 - ? Algorithms
 - Individual plan
- Process for re-assessment/monitoring tx effectiveness
 - Timing specified
 - Staff response to unrelieved pain specified
 - Routine monitoring specified
- Process for Staff education
 - Orientation, performance reviews
 - Annual review
- Resident/family education

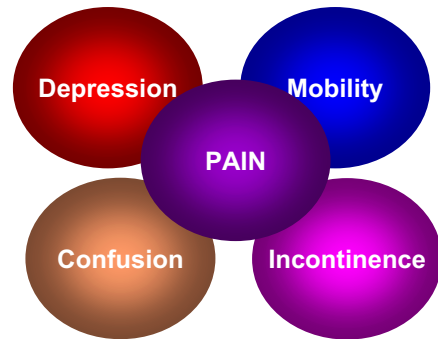


Quality Care: Ongoing Screening & Monitoring

- Institute use of standardized screening tools
 - cognitively intact
 - cognitively impaired
- Institute schedule to assess
 - Every MDS
 - Initial, quarterly, change of status, annual
- Institute schedule to routinely screen
 - Daily or weekly
- Institute schedule to reassess response to plan
- Designate responsibility/accountability
- Include resident, family, loved ones
- INDIVIDUALIZE CARE



Pain: A Multidimensional Phenomenon

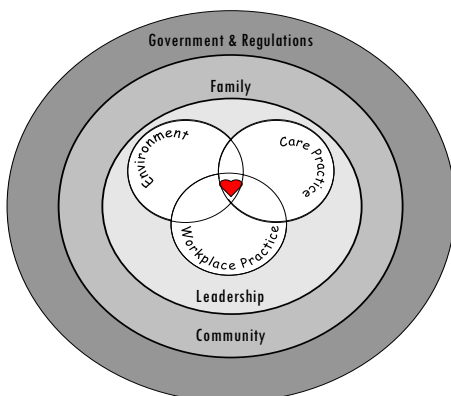


Effects all aspects of life

Does permanent damage

The Framework

Holistic Approach to Transformational Change
HATCh



Old Culture of Pain

- HCP knows best
- A little pain never hurt anyone
- Addiction is common
- Most people taking analgesics are drug seeking
- Demerol and darvon are drugs of choice
- Give as little as possible as infrequently as possible

New Culture of Pain

- Person knows best
- Pain = permanent damage
- Addiction is rare without previous history
- Most people are seeking relief
- Avoid demerol and darvon
- Prevent pain from occurring or returning – schedule meds



Strategies for Resident Centered Pain Care

- Respect reports of pain
- Respect individual differences
- Identify specific resident's goal for pain management
- Involve resident and family/loved ones in the pain management plan
- Determine resident preferences for pain management strategies
- Maintain consistent staff assignments
 - Involve CNAs



Key Points: Resident Centered Pain Care

- Self report is the gold standard
- People with chronic (persistent) pain often do not "look" in pain
- Expressions are even more blunted in the cognitively impaired
- Reports of pain must be taken seriously
- We DO NOT know another's pain and can't tell by simply looking.
- Vital signs are not a reliable source of help



Respect Individual Differences

- We ALL respond differently and uniquely to:
 - Pain
 - Pain relief goals
 - Pain medications
 - Non-pharmacologic interventions
 - Different people
- The differences are wide, variable
- Differences are **NOT predictable**



Resident Centered Differences: Medications

- We are physiologically different and use medications differently
- Because of wide & variable individual differences...
 - The right amount is the amount that works for each person
 - The right drug is the one that works for each person
 - 6-10 fold or > difference in doses needed
 - Different drugs work or don't work for different people



Key Points:

- In order to account for individual differences:
 - Complete a comprehensive assessment
 - Base the plan on assessment information
 - Establish a timeframe to reassess and evaluate effectiveness of the plan and revise
 - Expect wide variations even when pain is similar



Screening, assessment, re-assessment...the only way to know individual response

Screening for pain

- Who and When:
 - Schedule it routinely for ALL residents
 - Every shift
- What:
 - Use a standard tool for cognitively intact and cognitively impaired
- How:
 - Identify a level that requires reassessment and action
 - Level 3 (0-10 scale) or any level unacceptable to the resident
 - Assign written responsibility & accountability
 - CNAs as part of daily care
 - **Everyone who sees resident is also accountable to recognize and report pain**
- Why:
 - To identify residents with pain, plan to treat pain and evaluate treatment effectiveness



Identify Specific GOAL for Relief

- Resident determined
 - Number on the scale
 - Functional goal
- Measure progress in reaching goal
- Evaluate effectiveness of the plan to reduce pain and reach goal



Goal: Screening

- Residents are screened routinely for pain
AND...
- When resident reports pain, a comprehensive pain assessment is done and results in changes in the plan of care and a plan for reassessment



Key Points: Screening

- With appropriate policy, anyone can (and should) screen
- Must be scheduled and routine for all
- Screening scores/observations must be documented and tracked
- Pain or discomfort on screening must → **comprehensive assessment**

Keys to Assessment

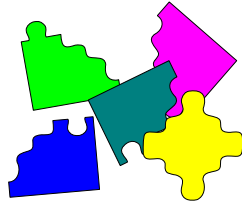
MDS Pain Scale

- MDS reporting
 1. No pain
 2. Pain less than daily
 3. Pain daily
 - Horrible/excruciating
 - Mild
 - Moderate
- **NOT** an assessment tool
- Measures outcome only at one point in time



Categories for assessment

- Pain
 - Rating
- Relief
 - Relief rating
- Effects of pain on the person
- Side effects
- Physical findings
- The plan
- Response to treatment



Asking the Right Questions

- Comprehensive assessment
 - Not just pain
 - Put the pieces together
 - Think clinically
 - Follow through after assessment



Reassessment

- When
 - Within the timeframe that the intervention is expected to work
 - PO meds = 1 hour
 - SC meds = 30 minutes
 - IV meds = 5 minutes
 - Medications at steady state
 - Scheduled review no less than daily for moderately severe to severe pain
 - Scheduled whenever an MDS is completed and quarterly
 - Whenever pain is reported

Pain and Cognitive Impairment

- The cognitively impaired (CI) are at ↑ risk for poor pain management
 - Pain is documented less frequently for CI elders,
 - Less analgesic is prescribed and administered for CI elders

**Self-report is the gold standard –
Everything else is a guess**

- Cognitive impairment does not preclude self-report
 - Evaluate the ability to provide verbal reports in ALL communicative patients
 - DO NOT make assumptions based on diagnosis or measured cognitive status

Tools for those unable to self report

No one "best" tool yet

Reference

- Herr K, et al. (2006) Tools for Assessment of pain in nonverbal older adults with dementia: A state of the science review. *J Pain and Symptom Mgt.* 31(2): 170-192



Best Practice: The Cognitively Impaired

Use the following in this order:

1. Self report
2. Search for potential causes of pain
 - "assume pain is present"
3. Observe resident behaviors
4. Surrogate reporting
5. Attempt an analgesic trial

American Society for Pain Management Nursing, 2006



Best Practice, (continued)

- Establish a procedure for pain assessment
- Use behavioral assessment tools as appropriate
 - Not a pain intensity measure
 - Can't compare to scales
- Minimize emphasis on physiologic indicators
- Reassess and document

Unable to Self-Report: Look at the Clinical Picture

- Prior pain history
- Current diagnoses causing pain
- Observe subtle behavior changes
 - Change in sleep, belligerence, withdrawal, etc.
 - Responses often blunted
 - Get to know the resident
- Ask family and staff about behavioral indicators of pain
- Document behavior as pain behavior
- Empirical evidence

Position Statement: Pain Assessment in the Nonverbal Patient.
American Society for Pain Management Nursing, 2006

If pain is possible - TREAT it!



Key Points:

Observational Tools

- Behavioral “tools” measure change in behavior NOT pain intensity
- Comprehensive assessment must follow
- Can NOT use behavioral tool to contradict self report
- Staff or family proxy ratings
 - Staff generally underestimates
 - Families tend to overestimate



When to Assess

- At first point of contact & routinely
 - On admission
 - With every MDS and at each quarterly review
- When pain changes or condition changes
- With each new report of pain or when pain is suspected
- When performing painful procedures
- With unrelieved pain
- When changing care settings

AMDA Chronic Pain Management Guidelines, 1999;
AGS Guidelines for Persistent Pain in Older Persons, 2002



Quality Care: Assessment

- Determine schedule for assessments
- Evaluate tools for comprehensiveness
- Develop procedure for incorporating assessment data into plan of care
- Assign responsibility/accountability
- Determine process for monitoring residents response to plan of care
- Determine schedule for reassessment of pain



Goal: Complete Assessment

- Reports of pain result in comprehensive assessment by the nurse to evaluate pain, pain relief and effectiveness of plan
- AND
- Lead to care planning & treatment to diminish pain

Managing Pain

HELP!

- Identify early
- Prevent pain
 - Schedule meds and non-drug interventions
- Use multi-modal approaches
- Re-evaluate regularly
- Include resident and family in planning

Developing a plan: A Team Approach

- ◆ Interdisciplinary
- ◆ Comprehensive
 - Based on individual assessment
- ◆ Comprehensive in nature
 - ◆ Non-drug interventions
 - ◆ Medications based on assessment
- ◆ Communicated to others



**All pain management
is based on
individual response**



Key Point: Multimodal approach

- Basic needs
- Positioning, assistive devices, distraction
- Relaxation and imagery
- Music therapy
- Activities therapy
- Other non-pharmacologic interventions
- Counseling and support
- Medications - treat the whole person!
 - Non-opioid
 - Opioid
 - Adjuvant for neuropathic pain



Approaches to Persistent Pain

- Prevent pain from occurring or returning
- Comprehensive plan
 - Integrate non-drug interventions
 - Integrate expertise of the entire team
- **SCHEDULE** meds – not prn
- Anticipate and manage side effects



Key Point: Review MAR

- Giving PRNs more than 2 times/day for pain for other than incident pain?
 - Schedule the medication
 - "Resident may refuse"
- Giving breakthrough medication regularly with controlled release analgesic?
 - Increase the dose of the controlled release medication
- Regularly reporting pain?
 - Assess and plan to relieve it
- Look at 24 hour report log
 - ? Trends
 - Unrelieved pain



Developing the Plan

Assess:

- The pain
- The person
- The plan

Identify

- Goals of care
- Past successes and failures

Use a team approach to planning



Look at the whole person, family and friends

- Pain
- Depression
- Adjustment to losses
- Spiritual distress
- Existential distress
- Other problems
- Include resident, family & friends

Use:

Interdisciplinary team
 Counseling & support
 Activities
 Multimodal approach



Principles for using medications

- By the clock for persistent continuous pain - not PRN
- Based on individual problem
- By mouth whenever possible
- Adjusted to individual response
- Anticipate and manage side effects
 - prophylactic bowel management program for all taking opiates
 - anticipate and manage other sides at initiation of therapy



Using meds in the elderly

- Select based on the individual problem
- Start low
- Titrate more slowly
- Beware of the NSAIDs long term
- Evaluate effect at steady state
- Right plan for evaluation
 - AGS Guidelines for managing pain in older persons, J. AGS. 1998.



Don't Even Go Here!

- Darvon, Darvocet
- Demerol
- IM injections
- Anti-anxiety meds or sedatives for pain
- Ignoring pain reports
- Assume sleep = relief



Quality Care: Developing a Plan of Care

- Designate responsibility for development & oversight of plan
- Ensure that plan adheres to published clinical guidelines including nonpharmacologic and pharmacologic interventions
- Address resident goals
 - Include resident, family in care planning whenever possible

Process Improvement: Why bother?

- It's all about providing the best possible care to all residents
 - It's about clinical practice!
 - Not a pencil pushing exercise
- Make it clinically relevant...
"What difference does this make to residents?"



Steps: An organizational commitment

1. Interdisciplinary workgroup
2. Analyze current practices
3. Articulate & implement a standard of care
4. Establish policies and protocols
5. Provide education
6. Implement plan to track quality
7. Designate accountability/responsibility

Plan to track quality

- Identify a gap or opportunity
 - The 'no' on the checklist
 - Begin there
- Develop a plan to improve !!
- Pilot test the plan and revise as needed
- Implement the plan
- Reassess

- Involve staff in it all!



Summary

- All pain is based on individual response
- All pain management plans are based on individual response
- Use all team expertise
- Screen, assess, plan, evaluate, re-screen and/or revise the plan
- Track your successes and look for opportunities to improve
- A continuous process