Evaluating Pain in the Long Term Care Resident

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Learning Objectives

• Identify the risk factors associated with chronic pain in residents residing in long-term care settings
• Examine how the identification, assessment, and management of chronic pain has changed with implementation of MDS 3.0
• Discuss the implications of pain management on the survey process and the role of new Quality Measures in defining effective pain management
• Define options to manage chronic pain with a focus on those therapies that may have advantages in older adults and/or those residing in long-term care settings

Faculty Disclosure

• Dr. Bakerjian is a member of the Omnicare Pharmacy and Therapeutics Committee
  – Dr. Bakerjian does not endorse any specific pharmaceutical products
• Dr. Bakerjian is a member of the research and development team for geriatricpain.org
Pain in Older Adults

- Pain is common but not normal
- Prevalence of pain is twice as high in those over age 60 (250 per thousand), compared with those under age 60 (125 per thousand)
- 60% of community-dwelling older adults experience substantial pain
- Impacts quality of life
- Major cause of ED visits, hospital admissions
- Annual cost of $61.2 billion (Byrd L, 2013)

Herr & Gerard (2011); Assessment and management of pain in older adults

Pain in Nursing Homes

- The prevalence of pain is reported as high as 85% in NHs
- Some reported improvement in prevalence of pain, however:
  - Over 75,000 long stay residents report mod-severe pain on a daily basis
  - Over 150,000 short stay residents report mod-severe pain on a daily basis

Pain in Older Adults

- Age-related pathophysiological changes
  - Changes in the nociceptive pathways
  - Cardiovascular changes
  - Renal and liver function
  - Musculoskeletal changes
- Psychological mediators of pain – altered pain beliefs, attitudes, coping measures
- Psychosocial factors – loss of independence, family, retirement
Common Pain Conditions

- Osteoarthritis
- Cardiac pain – angina,
- GI pain – gallbladder, peptic or duodenal ulcer, poor gastric motility
- Neuropathic pain – neuralgia, headache, diabetic neuropathy, neuropathy other causes
- Infections
- Cancer pain

Other Causes and Risks

- Surgery
- Procedures
- Trauma
- Inadequate management of pain
- Depression and other psychosocial causes
Recognition of Pain

• Recognizing pain is a key responsibility of nurses
• Pain is often under-recognized, under-diagnoses, under-treated
• Nurses are the first line in caring for older adults in nursing homes and need to improve pain assessment

MDS 3.0 SECTION J: HOW HAS IT HELPED US ASSESS AND MANAGE PAIN?

Identification, assessment, and management of chronic pain changes with implementation of MDS 3.0

Pain – Section J

• MDS 3.0- Section J documents assessment elements
• Requires a resident interview or staff assessment
  – Presence of pain
  – Frequency of pain
  – Effect on function
  – Intensity
  – Management
  – Control
**J0100 Importance of Pain Management**

- Pain can cause suffering and is associated with:
  - Inactivity
  - Social withdrawal
  - Depressed mood
  - Functional decline
- Pain can interfere with participation in rehabilitation.
- Effective pain management interventions can help to avoid these adverse outcomes.

**J0200 Should Pain Assessment Interview Be Conducted?**

- Most residents capable of communicating can answer questions about how they feel
- Obtaining information about pain directly from the resident is more reliable and accurate than observation alone for identifying pain
- Use staff observations for pain behavior only if a resident cannot communicate
  - Verbally
  - With gestures
  - In writing

**Pain Assessment Interview: J0300-0600**

- Interview any resident not screened out by J0200
- The interview consists of 4 questions
- Begins with the primary question
  - J0300 Pain Presence
- Includes 3 follow-up items
  - J0400 Pain Frequency
  - J0500 Pain Effect on Function
  - J0600 Pain Intensity
Pain Assessment Interview Guidelines

- The look-back period for all pain interview items is 5 days.
- Conduct the interview close to the end of the 5-day look-back period.
- Skip to the Staff Assessment if the resident is unable to answer J0300 Pain Presence.
- Stop the interview and skip to the Staff Assessment if the resident is unable to answer J0400 Pain Frequency.

J0800/ J0850 Staff Assessment for Pain

- Residents who cannot verbally communicate about their pain are at particularly high risk for underdetection and undertreatment of pain
- Severe cognitive impairment may affect ability of residents to communicate verbally
  - Limits availability of self-reported information about pain
  - Fewer complaints may not mean less pain
- Individuals unable to communicate verbally may be more likely to use alternative methods of expression to communicate pain

J0800/ J0850 Importance

- Some verbal complaints of pain may be made and should be taken seriously.
- Unrelieved pain adversely affects function and mobility, contributing to:
  - Dependence
  - Contractures
  - Skin breakdown
  - Weight loss
- Pain reduces quality of life and is linked to depressed mood, diminished self-confidence and self-esteem, as well as to an increase in behavior problems.
Indicators of Pain

• Non-Verbal Sounds include but not limited to:
  - Crying
  - Whining
  - Gasping
  - Moaning
  - Groaning
  - Other audible indications

• Vocal Complaints of Pain include but not limited to:
  - “That hurts.”
  - “Ouch.”
  - “Stop.”

Indicators of Pain

• Facial Expressions include but not limited to:
  - Grimaces
  - Wincing
  - Wrinkled forehead

• Protective Body Movements or Gestures include but not limited to:
  - Bracing
  - Guarding
  - Rubbing/ massaging a body part
  - Clutching/ holding a body part during movement

J0800 Conduct the Assessment

• Review the medical record.
  - Look for documentation of indicators of pain.
  - Confirm presence of indicators of pain with direct care staff on all shifts who work with resident during ADLs.

• Interview staff.
  - Question staff who observe or assist the resident.
  - Ask about presence of each indicator not in the record.

• Observe the resident.
J0800 Assessment Guidelines

• The look-back period is 5 days.
• Some symptoms may be related to pain:
  – Behavior change
  – Depressed mood
  – Rejection of care
  – Decreased participation in activities
• Do not report these symptoms here as pain screening items.

Challenge: Assessment Documentation

• Facilities do not use consistent or comprehensive assessment forms
• Do not meet all requirements of Ftag 309
• Recommend geriatricpain.org
  – Availability of cognitively impaired and intact forms
  – Forms are downloadable in Word format
• Contain all required elements

Were Pain Assessment Standards Met (Ftag 309)?

• History of pain & its treatment
• Characteristics of pain
• Impact of pain on quality of life
• Factors that precipitate pain
• Strategies or factors that reduce pain
• Associated pain symptoms
• Physical Examination
• Current medical condition & medications
• Resident goals for pain management
Pain Assessment Tools

- Downloadable pain assessment forms in Word
- Available on www.geriatricpain.org
- Can be customized
- Both cognitively intact and cognitively impaired comprehensive assessments
Pain Assessment Review

- REMEMBER - conduct a pain assessment interview if at all possible
- When determining the assessment for pain intensity, use either the Verbal Descriptor Scale or the Numeric Rating Scale, not both
- Complete the staff assessment for pain only if an interview cannot be completed
- Complete a pain assessment even if the resident denies pain
- MDS 3.0 has improved our ability to detect pain in older adults

Define options to manage chronic pain with a focus on those therapies that may have advantages in older adults and/or those residing in long-term care settings

TREATMENT OF PAIN

Management of Pain

- Based on assessment - facility, attending prescriber, & staff collaborate to manage pain
- Develop appropriate interventions to prevent or manage pain
- Interventions may be integrated into care plan or included as a specific pain management need or goal
- IDT & resident develop pertinent, realistic & measurable goals for treatment
- Pain management approaches must follow clinical standards of practice
Non-Pharmacological Interventions

- There is not great research evidence that these work because they have been poorly studied
- There is great anecdotal evidence for their use
  - Alterations in environment for comfort
  - Physical modalities – cold/heat, positioning, massage
  - Exercises to reduce stiffness, prevent contractures
  - Cognitive/behavioral interventions
  - CAM – herbal supplements if ordered
  - Distraction-guided imagery, relaxation
  - Music
- Staff should attempt all non-pharm interventions to determine if they might work

Pharmacological Interventions

- IDT is responsible for developing individualized pain management regimen
- A systematic approach for meds & doses is important
- Addressing underlying cause of pain
- Administration timing – PRN vs routinely
- Combining short & long acting drugs
- All medications, including opioids or other potent analgesics, must be dosed according to standards
- Clinical record should reflect ongoing communication with prescriber

MEDICATION SAFETY

- Prescribers include physician, nurse practitioners, physician assistants, and in some cases, pharmacists
- NURSES are responsible for administering pain medications appropriately as ordered
  - 5 Rights
  - Consideration of routine versus PRN meds
- NURSES are responsible for
  - Evaluating the effectiveness of the pain med
  - Assessing for side effects/adverse effects
  - Communicating to the prescriber
Non-Opioids

- Two common non-opioids types, safety concerns with both
- Tylenol – pain reliever
  - Maximum dose 3Gms/24 hrs
  - Concern for liver damage
- NSAIDs – anti-inflammatory
  - Dosage varies depending on the drug
  - Frequent cause of GI bleeding
  - Concerns for renal damage at high, prolonged doses

Opioids

- History of underuse of opioids – pendulum swinging the opposite way
- Huge problem with diversion – hence the problem we have with the DEA
- Now greater risk of overdose & death due to prescription drugs than cocaine, heroin
- Prescribers now must include a risk assessment prior to ordering
- The biggest at risk population – those with history of alcohol or drug abuse

MANAGING OPIOID SIDE EFFECTS

- Constipation is the main problematic side-effect
  - Ensure a bowel regimen in place at the onset of opioid use
  - Increases in dietary fiber and water (not coffee, tea or other diuretic inducing drinks)
- Drowsiness, cognitive change, delirium – fall risk, notify prescriber
- Respiratory depression – notify prescriber
- Nausea – meds with food, avoid spicy foods
- Pruritis – cool compress, moisturizers
Nurses Responsibility

• Monitor effectiveness of medication – this is the an important monitoring task
  – Does the medication work?
  – If so, for how long?
• If the opioid ineffective, higher doses and greater numbers of opioids are not better
• Need to remember, opioids can have severe side effects
• There can be other affects of opioids that people find attractive, even though the pain is not relieved

Challenge: Treatment

• Non-pharm interventions do not always work
• Many pain medications have extensive side-effects
  – NSAIDs – gastric bleeding, renal failure
  – Opioids – tolerance, pseudo-addiction, constipation
• IDT is essential – pharmacist, care team, prescriber – it is difficult to get them there at the same time
• IDT Team need to ensure that patients with chronic or constant pain have both long and short acting meds
• NHs do a terrible job of monitoring overall
• Therefore, pain interventions are inconsistently revised
• It is a pain to get pain meds with the new DEA regulations

Pain Management for Cognitively Impaired Residents

• Management of pain in cognitively impaired residents is a special challenge
• Using an evidence based assessment helps (geriatricpain.org)
• Serial-Trial Intervention might help
  Available on geriatricpain.org
Serial Trial Intervention

- Systematic process used to assess and proactively treat pain in moderately to severely cognitively impaired adults
- Individuals with dementia use behaviors instead of specific verbal complaints to express pain
- If basic care (feeding, toileting, or positioning) doesn’t resolve behaviors trial of analgesia may be helpful
- Protocol has 5 steps to guide the intervention

CARE PLANNING

Care Processes for Pain Management

- Assess for potential for pain
- Recognize the onset or presence of pain
- Address & treat underlying cause for pain
- Develop & implement pain interventions
- Identify & use specific strategies for different levels or sources of pain
- Monitor appropriately
- Modify pain interventions/strategies as needed
Planning: Monitoring, Reassessment, Care Plan Revision

- Monitoring response over time helps to determine effectiveness of treatments
- Adverse consequences to medications can be anticipated & reduced
- Identification of target signs of pain
- Inadequate control of pain requires a revision of intervention
- Resolution of pain should be documented and treatment tapered or discontinued

Challenges: Consistency

- Nurse to nurse communication is inconsistent
  - Between and across shifts and units
  - Between nurse and prescriber
  - At IDT
- Quality of communication is poor
  - Rushed
  - Incomplete information
- Inadequate time for documentation

Discuss the implications of pain management on the survey process and the role of new Quality Measures in defining effective pain management

REGULATIONS:
REVIEW OF F-TAG ELEMENTS
What is F-tag 309?

- F-tag 309 focus is overall quality of care – revised 5 years ago
- Requires that NHs provide for the highest practicable level of function & well being
  - Comprehensive resident assessment – beyond MDS 3.0
  - Care plans must address mental, physical, & psychosocial needs
- Ensure residents obtain optimal improvement or do not deteriorate
  - Within resident’s right to refuse
  - Limits of recognized pathophysiology & normal aging

New Pain Aspects of F-tag 309

- Pain management has specifically developed guidelines within this F-tag
  - New definitions of terms
  - New investigative protocol
  - Defining care processes for pain management
  - Defined steps in pain recognition, assessment, management, interventions, care plans
  - Investigative protocol for surveyors specific to pain

Management of Pain Standards

- Based on assessment - facility, attending prescriber, staff must collaborate to manage pain
- Develop appropriate interventions to prevent or manage pain that are integrated into care plan
- Pain management approaches must follow clinical standards of practice
- Both pharmacological and non-pharmacological treatments must be considered
Investigative Protocol

• QOC related to recognition & management of pain
  – Determine whether facility has provided & resident has received care & services to address & manage pain
  – Applies to residents who state they have pain, who display indicators of pain, are assessed with pain, receives pain treatment, has elected hospice benefit for pain management

Survey Procedures

• Observe residents
• Interview residents or family
• Interview nurse aides
• Review records
  – Assessment
  – Care plan, including revisions
• Interview health care practitioners & other health professionals

Determining Compliance

• Facility is in compliance if EACH resident has their pain managed in alignment with their goals to attain the highest practicable physical, mental, & psychosocial well-being
• Recognized & evaluated pain to determine cause
• Developed & implemented comprehensive care plan
• Provided measures to minimize, prevent, or treat pain
• Monitored effects of interventions
• Communicated with health care practitioner when appropriate to obtain new orders or revise current orders
Noncompliance Determination

- Failure to show adequate proof that ALL of the previous steps are followed is non-compliance
- Non-compliance can be at any one step along the way
  - Recognize & evaluate
  - Intervene & treat
  - Prevent or minimize
  - Monitor
  - Communicate & coordinate

Avoiding a Pain F-Tag Citation

If it Guides Surveyors, Shouldn’t You Follow?

- F-Tag 309 uses evidence-based practice recommendations
- Expectations
  - Screening to determine if residents experience pain
  - Comprehensively assessing the pain
  - Identifying when pain can be anticipated
  - Developing and implementing a plan, using pharmacologic and non-pharmacologic interventions to manage pain and/or try to prevent the pain, consistent with the resident’s goals
Three Aspects to Compliance
with 42 CFR 483.25, F309, Quality of Care for Assessment and Management of Pain

1. Facility must identify each resident having or at risk for pain and anticipate what procedures, care, or treatments might produce pain, and evaluate the resident regarding the characteristics and causes of the pain.

2. Facility must provide the care and services for the resident to attain or maintain his/her goals for pain management and comfort that is consistent with current standards of practice, assessment and plan of care.

3. The level of pain management is consistent with a resident’s potential to achieve or maintain his/her highest practicable level of physical, mental, and psychosocial well-being.
PAIN MANAGEMENT STANDARDS FOR QUALITY CARE

Quality Pain Care for Elders

The Pain F-tag 309 may motivate you, but it is really SHOULD be about providing high quality care.

Approach

- Screening for pain & treat if needed
- Perform comprehensive pain assessment
- Communicate with health care provider, resident, family, IDT
- Develop comprehensive care plan to include intervention
- Implement the plan
- Monitor & revise plan as needed
Knowledge of Pain

- Staff must know pain essentials
- Types of pain
- How to perform a comprehensive assessment
- How to document findings
- Understanding of both pharmacological & non-pharmacological interventions
- How to monitor & revise plans
- Effective communication

Pain Descriptors

- Acute versus Chronic
- Pain pattern – constant, intermittent
- Character – stabbing, burning, dull, aching
- Location of pain

Pain Impacts

- Physiological changes – heart rate, resp rate, BP, diaphoresis, flushing
- Loss of appetite
- Insomnia
- Decreased mobility
- Social isolation
- Enjoyment of activities
Pain Related Diagnoses

• Admission diagnoses helps nurses to anticipate resident pain & types of pain
• Nociceptive pain
  – Somatic pain – arthritis, fractures
  – Visceral pain – abdominal pain, cancer
• Neuropathic pain – neuralgias, diabetic neuropathy

Quality

• Using a quality approach will help facilities to improve care over time
• Use pain as a QAPI project
• Be PROACTIVE instead of REACTIVE
• Multiple resources available

IMPROVING QUALITY OF PAIN CARE
Quality Measures for Pain

- Percent of Residents who Self-Report Moderate to Severe Pain (Short Stay)
- Percent of Residents who Self-Report Moderate to Severe Pain (Long Stay)

How to Improve

- Establish a pain working group- Charge nurses, CNAs, Medical Director, others
  - Define what would be “optimal” care processes
  - Examine current practice, identify poor processes
  - Devise a QAPI project to improve processes
- Design good communication tools & processes
  - Huddles
  - Interact II Tools – Stop and Watch, SBAR
- Use standardized but comprehensive forms (i.e. assessment forms from geriatricpain.org OR QI tools from Advancing Excellence)

CMS QAPI Framework

1. Design and Scope
2. Governance and Leadership
3. Feedback, Data Systems, and Monitoring
4. Performance Improvement Projects
5. Systematic Analysis and Systemic Action
Design and Scope

- Comprehensive, ongoing program that includes all departments of the NH
- Focuses on safety, quality of care, QOL, resident choice and care transitions
- Based on best available evidence
- QAPI plan

Governance and Leadership

- Boards, owners, executive leadership will be accountable
- Cultural environment, organizational climate to provide capacity for PI
- Required to provide sufficient resources
- Must address sustainability

Feedback, Data Systems & Monitoring

- Data will come from multiple sources to include residents, family & staff
- Feedback system should include complaints and adverse events
- NHs will need to set targets and will have national benchmarks
Performance Improvement Projects

- NHs may have a number of PIPs
- PDSA process will be emphasized
- PI is a team activity

Systematic Analysis & Action

Examining the systems & designing solutions that address Systems NOT People will be essential

Conclusion

- Pain management is a complex problem
- Requires a systems approach
- Leadership need to assess how well the organization is managing pain
- Implement QAPI performance improvement project (PIP)
- Measure progress
Pain Assessment Resources

- Advancing Excellence website
  - [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
  - Click on the pain goal for resources
Resources and Guidelines

- Pain Website for Nursing Homes
  - www.GeriatricPain.org
- Advancing Excellence in America’s Nursing Homes
  - http://nhqualitycampaign.org/
- End of Life/Palliative Education Resource Center
  - http://www.eperc.mcw.edu/ff_index.htm
- City of Hope Pain Resource Center
  - http://prc.coh.org/elderly.asp
- Quality Improvement Organizations
  - www.medqic.org

Resources and Guidelines

- American Geriatrics Society (AGS): Clinical Guidelines
  - www.americangeriatrics.org
- American Medical Directors Association (AMDA): Clinical Guidelines
  - www.amda.com
- American Pain Society
  - www.amapain.org
- Agency for Health Care Research and Quality (AHRQ): Clinical Guidelines
  - www.ahcpr.gov/clinic/cpgonline.htm
- National Guideline Clearinghouse
  - www.guideline.gov
- National Pain Education Council (NPEC)
  - www.npecweb.org

Resources and Guidelines

- American Academy of Hospice and Palliative Medicine
  - www.aahpm.org
- American Academy of Pain Medicine
  - www.painmed.org
- Hospice and Palliative Nurses Association
  - www.hpna.org
- Partners Against Pain
  - www.partnersagainstpain.com
- Resource Center for Pain Medicine and Palliative Care at Beth Israel Medical Center
  - www.stoppain.org/education_research/resources.html