

Tailoring Pain Management in the Long-Term Care Setting

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Case #1



Mildred is an 88yo female admitted to your facility following functional decline at home. She has chronic back pain and increasing requirements for Vicodin. Her doctor tries a sustained release morphine but the resident insists, "I need more Vicodin and Ativan." She has also had a decline in ADLs and is now bedfast. The surveyor tries to speak to Mildred but she falls asleep during the interview.

Case #2

Annie is 85 yo and recently fractured her arm after a fall. She is undergoing rehabilitation with plans to return home. She refuses to take pain medication because, "it makes me so goofy!"



Case #2 (cont.)

The surveyor asks you why this resident continues to report severe pain after 3 weeks in the facility and questions why the pain assessments indicate "0" or "no pain" on all nursing evaluations for the past several weeks.



Case #3

Woody is 79 yo and in a dementia unit. He is non-verbal. The resident is on scheduled acetaminophen 500mg 3x daily. He has had several recent falls and the staff considered adding additional pain medication but his daughter refused stating, “those medicines will just make him fall more.”



Case #3

The surveyors observe Woody and note that he is clenching his teeth and rubbing his head frequently – both signs that are listed as non-verbal indicators of pain in a prior care plan.



CMS Quality Indicator Survey

- 2-staged computer assisted survey process
- Designed to:
 - Improve consistency/accuracy of survey
 - Systematic/objective
 - Quality improvement tool
 - Focus resources on struggling facilities
- Survey process changed, guidance did not

QIS Process

- Offsite survey preparation
 - Review prior deficiencies, complaints, ombudsman reports
 - MDS data from facility is loaded on the surveyors’ tablet PC
- Entrance conference, brief tour, request of facility information

QIS Process- cont

- Randomly-generated sample
 - Admission sample is a review of 30 current or discharged residents (re-hospitalization, functional loss, death)
 - Census sample includes 40 current residents for observation, interview and record review (quality of care, quality of life)
 - MDS data used to calculate Quality of Care and Quality of Life Indicators for use in Stage II

QIS Process- cont

- Structure
 - Stage I: preliminary investigation of regulatory areas in admission and census samples; mandatory facility-level tasks (kitchen, dining areas, billing, QA program, medication administration, injection control)
 - Stage II: In-depth investigation of triggered care areas and/or facility-level tasks based on Stage I
- Interview with Resident Council President or Representative

Pain in MDS 3.0

- Presence: Patient reports pain or hurting at any time in last five days.
- Frequency: Patient asked how much of the time they experience pain or hurting in the past five days with possible responses of 1) almost constantly, 2) frequently, 3) occasionally, 4) rarely or 5) unable to answer.

MDS 3.0: Pain Intensity

- Numeric or verbal pain intensity scale: results of a resident interview asking residents to rate their pain over the previous 5 days on a scale from 1 to 10 using either a scale with numbers or words (mild, moderate, severe, very severe)

MDS 3.0 Pain: Function and Treatment

- Effect on Function: Pain has made it hard to sleep at night and/or has limited day-to-day activities.
- Treatment: Patient on a scheduled pain medication, is receiving as needed pain medications or non-medication interventions for pain now or in the past 5 days.

What the Surveyors Want...

- “Mindful Care”
 - Individualized care
 - Focus on quality of life
 - Resident-centered
- Pain placed in a prominent role in a facility's quality assurance program.

Management

- Interventions and treatments should be:
 - preceded by an assessment
 - developed with respect for whether pain is episodic or continuous
 - administered to meet resident’s need
 - monitored for effectiveness and/or adverse consequences

Pain Management - Criteria for Compliance

- Screened on admission and periodically
- Assessed causes, characteristics
- Developed a care plan
- Controlled pain & anticipated exacerbating treatments/activities
- Monitored effects of interventions
- Contacted health care practitioner when not controlled or with side effects
- Revised approach and relevance

What is Pain?

- “An unpleasant sensory and emotional experience”
- A complex phenomenon derived from sensory stimuli
- Interpreted by the individual, there are no biological markers for pain

Experience of Pain

- Pain is an experience that is highly individualized and multidimensional
- The patient’s and family’s account of their pain experience is the most valuable tool available to the clinician
- Avoid assumptions - not all patients want to be completely pain free

Who has Pain?

- As many as 83% of nursing home residents experience pain that impairs mobility, may cause depression, and diminishes quality of life.
- Pain is often unrecognized and not treated by health care providers.

Pain Management in Nursing Homes

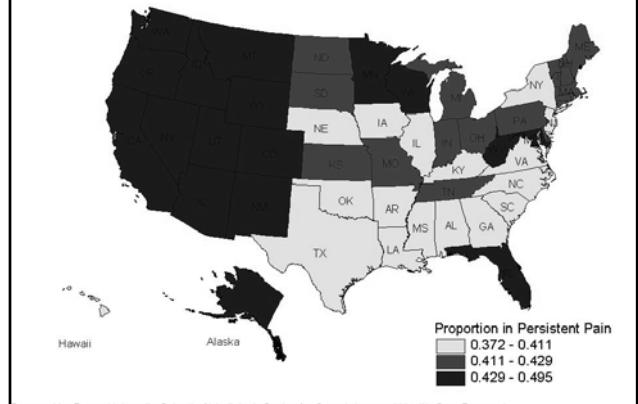
- 40% of cancer patients discharged to a nursing home have daily pain.
- Of those in pain, one in four do not have any analgesic prescribed... NOT EVEN acetaminophen.

Persistent Pain

- 41% of persons who had pain at their first assessment also had either moderate daily pain or an excruciating level of pain at their next assessment (completed 60-180 days later).
- Of those persons with two MDS assessments, 1 in 7 were in persistent severe pain.

Teno, JAMA 2001

Rate of Persistent Pain in US Nursing Homes



Why Focus on Pain?

- Pain is a symptom most expected and most feared by dying patients.
- Unrelieved pain can have enormous physiological and psychological effects on residents and their loved ones.

Why Focus on Pain?

- Pain negatively affects quality of life by impairing daily functions, social relationships, sleep and/or self worth.
- Although pain can be relieved in up to 90% of residents, many residents receive inadequate or no treatment

Effects of Pain in the Elderly

- Impairs mobility, slowing rehabilitation
- Decreases socialization
- Increases depression
- Increases sleep disturbances
- Contributes to cognitive impairment
- Contributes to poor food intake and malnutrition
- Increases morbidity

Misperceptions about Pain

- Pain is normal aging.
- We must bear pain.
- Pain is punishment for past actions.
- Cognitively impaired persons have a high tolerance for pain.
- Elderly persons are likely to become addicted to pain medications.
- Pain means that death is near.

Barriers to Pain Assessment in the Elderly

- Cognitive impairment
- Communication barriers
- Cultural barriers
- Atypical presentations – isolation, anorexia
- System barriers
 - Staff training and access to appropriate tools
- Failure to report pain
- Fear of addiction.....

Addiction . . .

- Psychological dependence
- Compulsive use
- Loss of control over drugs
- Loss of interest in pleasurable activities
- Continued use of drugs in spite of harm
- A rare outcome of pain management
 - particularly, if no history of substance abuse

Addiction

- Consider
 - substance use (true addiction)
 - pseudoaddiction (undertreatment of pain)
 - behavioral / family / psychological disorder
 - drug diversion

Tolerance

- Reduced effectiveness to a given dose over time
- Not clinically significant with chronic dosing
- If dose is increasing, suspect disease progression

Physical Dependence

- A process of neuroadaptation
- Abrupt d/c may induce withdrawal symptoms
- If dose reduction required, reduce by 50% q 2–3 days

Substance Users

- Can have pain too
- Treat with compassion
- Protocols, contracting
- Consultation with pain or addiction specialists

ABCs of Pain Assessment

- **A**sk about and **A**ssess pain regularly.
- **B**elieve the patient and family in their reports of pain and what relieves it.
- **C**hoose pain control options appropriate for the patient, family, and setting.
- **D**eliver interventions in a timely, logical, and coordinated fashion
- **E**mpower patients and families. **E**nable them with as much control as possible.

Comprehensive Pain Assessment

- If pain is identified upon screening, perform comprehensive pain assessment
- Elements of complete assessment
 - Location
 - Intensity or severity
 - Quality
 - Duration
 - Pattern
 - Current treatment
 - Response to treatment

Organizational Commitment

- Develop interdisciplinary workgroup
- Analyze current pain management practices
- Analyze and implement pain management practice consistent with guidelines
- Establish accountability for pain management

Organizational Commitment

- Provide information about pharmacologic and non-pharmacologic interventions to clinicians
- Promise quick response to report of pain
- Provide education for staff
- Continuous evaluation and improvement of pain management process

Disciplinary Roles

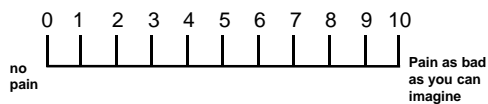
- RN: screening and all components of assessment
- OT/PT: screening, non-analgesic elements of assessment
- CNA: intensity ratings, understand misconceptions
- SW: assess misconceptions

0-10 Scale and Verbal Descriptors

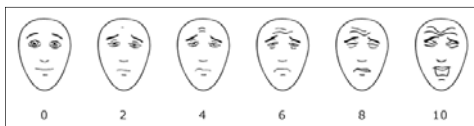
1-4: mild

5-6: moderate

7-10: severe



None – mild – moderate – severe



Faces Pain Scale – Revised (FPS-R) Hicks CL, von Baeyer CL et al.

0-10 scale and pain impact

					relate
				walk	walk
		sleep	sleep	sleep	sleep
		active	active	active	active
		mood	mood	mood	mood
	work	work	work	work	work
enjoy	enjoy	enjoy	enjoy	enjoy	enjoy
3	4	5	6	7	8

Increasing pain on 0-10 scale

Assessing Pain in Mild to Moderate Cognitive Impairment

- “ASK!”- Use standard scale, ask resident about present pain
- Observe for verbal and nonverbal pain-related behaviors and ensure understanding of tool
- Observe for changes in usual activities and functions

Resident Observation: Pain in the Cognitively Impaired Resident

Vocalization (crying, moaning, and groaning)

- Less obvious- grunting, chanting, calling out, noisy breathing, and asking for help

Body Movements (guarding)

- Less obvious- rigid, tense posture, fidgeting, jaw clenching, increased pacing, rocking, restricted movement, gait or mobility changes such as limping, and resistance to moving

Abbey Pain Scale
For measurement of pain in people with dementia who cannot verbalise.

How to use scale : While observing the resident, score questions 1 to 6.

Name of resident :

Name and designation of person completing the scale :

Date : Time :

Latest pain relief given wasat.....hrs.

Q1. **Vocalisation**
eg whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3 Q1

Q2. **Facial expression**
eg looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3 Q2

Q3. **Change in body language**
eg fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3 Q3

Q4. **Behavioural Change**
eg increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3 Q4

Q5. **Physiological change**
eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3 Q5

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eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor
Absent 0 Mild 1 Moderate 2 Severe 3 Q5

Q6. **Physical changes**
eg skin tears, pressure areas, arthritis, contractures, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3 Q6

Add scores for 1 - 6 and record here Total Pain Score

Now tick the box that matches the Total Pain Score

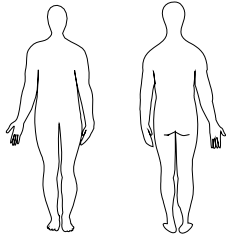
0 - 2 No pain 3 - 7 Mild 8 - 13 Moderate 14 + Severe

Finally, tick the box which matches the type of pain

Chronic Acute Acute on Chronic

Abbey, J, De Bello, A, Piles, M, Easonman, A, Giles, L, Parker, D and Lowrey, B.
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Location



- Indicate areas of pain
- Describe different areas of pain
- Describe different types of pain

Physical Findings

- Observe the site of pain
- Note skin color, warmth, irritation, integrity

Temporal characteristics

- When did the pain start?
- Does the pain vary with time of day or activity?
- How long does the pain last?

Aggravating & Alleviating Factors

- What makes the pain better or worse?
- Is the pain affected by movement? Position?
- Do any non-pharmacological methods help?

Depression

- In the last month have you
 - felt a lack of pleasure in life?
 - felt depressed ?
 - do you have an appetite? If, no does any food sounds good?
- Geriatric Depression Scale
- Cornell Depression Scale



Analgesic history



- Current medication's onset, maximal analgesia, and duration

After you take your medicine....

- ✓ How long till it starts working?
- ✓ When do you get the best relief?
- ✓ How long does it last?

Analgesic History

- PRN vs. scheduled use
- Side effects
- Past analgesics
- Drug phobias

Patient Goals and Expectations

What is the patient's pain relief goal:

- on a scale?
- in terms of function?

Goal: ____/10
Patient wants to:
__ Sleep
__ Walk
__ Bungee Jump
__ Other:

World Health Organization (WHO) Analgesic Ladder

- Step 1 – Mild pain
 - Non-narcotic medication “around the clock”
- Step 2 – Moderate pain
 - Add an opioid for moderate pain
- Step 3 – Severe pain
 - Strong opioid “around the clock”

Match the therapy to the intensity of pain

- Mild pain: acetaminophen, NSAIDs
- Moderate pain: opioid combination analgesics, “weak opioids”, NSAIDs
- Severe pain:
“strong” opioids.

Opioid Examples

WHO Step 2- Moderate pain

- Codeine: Tylenol ® with codeine
- Hydrocodone: Vicodin®, Lortab®, Lorcet®

WHO Step 3 - Severe pain

- Fentanyl Transdermal - Duragesic®
- Morphine - MS Contin®, OramorphSRTM, Kadian®, RoxanolTM

When a patient is receiving sustained release opioids...

- Always have an order for breakthrough pain.
Use an immediate release opioid at a strength equivalent to 10-20% of the 24 hour dose of the sustained release dose. Order q1-2h prn
- Never order more than one sustained release preparation at a time

When a patient is receiving combination analgesics

- Only one combination analgesic should be ordered at a time
- Make sure the patient is taking no more than 4000mg acetaminophen in 24h



Consider adjuvants if the patient has neuropathic pain

- Tricyclic antidepressants (amitriptyline, nortriptyline, desipramine). Start at 25mg, increase by 25mg q3-7 days until relief or unacceptable side effects
- Anti-convulsants (gabapentin, carbamazepine, phenytoin) - dose as would for seizures

Prevent and manage constipation

- Ongoing assessment in *every* patient receiving opioids
- Increase fluids and fiber if patient is able
- Scheduled stool softeners are NOT enough
- Stimulant laxatives

Medications to Avoid in the Elderly

- Meperidine (Demerol®): toxicity, lowers seizure threshold, renal dysfunction, increase delirium
- Propoxyphene (Darvon®) (norpropoxyphene): poor analgesic
- Pentazocine (Talwin®): poor analgesic, causes delirium and agitation

Non-Pharmacological Interventions

- Exercise
- Positioning
- Transcutaneous electrical nerve stimulation (TENS)
- Acupuncture
- Cutaneous Stimulation Techniques
 - Hot/cold
 - Massage
 - Pressure or vibration

Non-Pharmacological Interventions

- Relaxation and imagery
- Distraction and reframing
- Psychotherapy, cognitive behavioral therapy
- Hypnosis
- Peer support groups
- Pastoral counseling

Key Steps in Monitoring Pain

- Monitor for pain at least daily
- Utilization of pain tool
- Responsibility for monitoring designated
- Results of monitoring ACCURATELY recorded in medical record
- Update care plan based on monitored results

Key Steps in Care Planning

- Assessment data incorporated into care plan
- Responsibility for care plan development designated
- Care plan includes pharmacological and non-pharmacological interventions
- Monitoring component
- Refer to a standardized “*pain algorithms*”

Case #1

Mildred is an 88yo female LTC resident admitted following functional decline at home. She has chronic back pain and increasing requirements for Vicodin. Her doctor tries a sustained release morphine but the patient insists she needs more Vicodin. She has also had a decline in ADLs and is now bedfast. The surveyor tries to speak to the Mildred but she falls asleep during the interview.



Were We in Compliance?

- Screen on admission and periodically
- Assess causes, characteristics
- Develop a care plan
- Control pain & anticipated exacerbating treatments/activities
- Monitor effects of interventions
- Contact health care practitioner when not controlled or with side effects
- Revise approach and relevance of treatment plan

Case #2

Annie is 85 yo and recently fractured her arm after a fall. She is undergoing rehabilitation with plans to return home. She refuses to take pain medication because, “it makes me so goofy!”



Case #2 (cont.)

The surveyor asks you why this resident continues to report severe pain after 3 weeks in the facility and questions why the pain assessments indicate “0” or “no pain” on all nursing evaluations for the past several weeks.



How about in this case?

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The surveyors observe Woody and note that he is clenching his teeth and rubbing his head frequently – both signs that are listed as non-verbal indicators of pain in a prior care plan.



And this one.....

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Questions?



A screenshot of the AMDA (American Medical Directors Association) website. The browser address bar shows the URL: http://www.amda.com/ondirect/pain/index.dfm. The website header includes the AMDA logo and the text "American Medical Directors Association". A navigation menu contains links for ABOUT AMDA, AMDA FOUNDATION, CAREER OPPORTUNITIES, CALENDAR, LINKS, LIC DIRECT, and CONTACT US. A search bar is located in the top right corner. The main content area features a sidebar with a menu of categories such as HOME, ADVOCACY, AWARDS PROGRAM, CERTIFICATION, CLINICAL TOOLS, CONSUMER CORNER, EDUCATION & MEETINGS, GOVERNANCE, INDUSTRY RELATIONS, MANAGEMENT TOOLS, MEMBERSHIP, NEWSROOM, PUBLICATIONS, and PRODUCTS. The main content area displays the title "AMDA's Clinical Practice Guideline on Pain Management in the Long Term Care Setting" with a release date of April 2004. Below the title, there is a section for "CME Information" and "Eligibility for AMA PRA Credit". The "Eligibility for AMA PRA Credit" section states that physicians with current and valid licenses in the United States, Canada, or Mexico who read the continuing medical education content contained in this self-study test of the Clinical Practice Guideline (CPG) on Pain Management in the Long Term Care Setting and who complete the corresponding tests and evaluations and submit them to AMDA as directed at the bottom of the Post-Test and Evaluation Form will receive category 1 credit. There is a \$14 fee for processing and mailing the credit certificate for this educational activity. The "About This CPG" section states that this Clinical Practice Guideline (CPG) is sold separately from the self-study program. Individuals who wish to complete the self-study program but do not have this CPG may order it from AMDA. The cost is \$20 for AMDA members and \$30 for non-members (discounts are available for purchase through the AMDA website).