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

- 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, infection 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

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

<table>
<thead>
<tr>
<th>Physical Dependence</th>
<th>Substance Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>A process of neuroadaptation</td>
<td>Can have pain too</td>
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<tr>
<td>Abrupt d/c may induce withdrawal symptoms</td>
<td>Treat with compassion</td>
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<tr>
<td>If dose reduction required, reduce by 50% q 2–3 days</td>
<td>Protocols, contracting</td>
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<tr>
<td></td>
<td>Consultation with pain or addiction specialists</td>
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ABCs of Pain Assessment

• Ask about and Assess pain regularly.
• Believe the patient and family in their reports of pain and what relieves it.
• Choose pain control options appropriate for the patient, family, and setting.
• Deliver interventions in a timely, logical, and coordinated fashion
• Empower patients and families. Enable 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

0-10 scale and pain impact

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
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®) (norpropoxphene): 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

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Were We in Compliance?

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- Revise approach and relevance of treatment plan

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How about in this case?

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And this one…..

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Questions?