Improved Quality Measures Through Comprehensive Pain Assessment

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PREMIER THERAPY embrace the difference

Course Objectives:

1. Attendees will be able to explain and describe pain assessments for a variety of diagnoses.
2. Attendee will be able to explain how pain affects most Quality Measures.
3. Attendee will be able to describe a comprehensive pain management program that enhances quality of life of resident and decreases burden of caregivers.

Why we need to focus on a comprehensive pain management program?

Expectation of Improved Quality and Patient Outcomes

- Quality Measures
- Survey
- Re-hospitalization Rates

Accountable Care Organizations
Bundled Payment Initiatives

Support For A Comprehensive Pain Management Approach

- 2012 Research Study published in Journal of Gerontological Nursing found that more research needs to be completed on the effects of a comprehensive approach.
- The study also found that accuracy of pre-intervention resident assessment data and resulting QM/QI score is an important consideration.
- Results from previous studies show that nursing/physicians may not possess adequate expertise in pain management and that lack of education and inadequate use of processes of care often leads to underreporting of required MDS data elements, and QM scores.

Russell et al, *J Gerontol Nurs*, 2012

Measurement Variables

- Re-Admission Rates
- Discharge Setting
- Clinical Outcomes
- Length of Stay
- Patient/Family Satisfaction
- Department of Health Survey Results
- Cost per Episode
- Peer Comparison
- Specialty Focuses
- Labor Hours (PBJ)

Quality Measures

CMS' Keys to Quality Improvement

- At the global level, awareness and education across a broad spectrum of healthcare workers is necessary, while at the local level, each facility must attack the problem individually.
- At the core of each of these initiatives, improvement requires a facility to examine existing practices and update as necessary, perform root cause analysis, offer consistent and up-to-date staff education, and have reference tools available to support staff.

A Comprehensive Pain Management – Advancing Excellence

How Does Pain Management Benefit Residents?

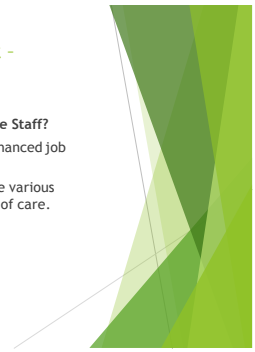
- Residents can express their wishes for pain management.
- Residents do not experience a decline in functional status due to uncontrolled pain.
- Residents are not at risk for depression due to uncontrolled pain.
- Residents do not experience a decline in quality of life due to unmanaged pain.

https://geriatricpain.org/advancing-excellence

A Comprehensive Pain Management – Advancing Excellence

How Does Pain Management Benefit Nursing Home Staff?

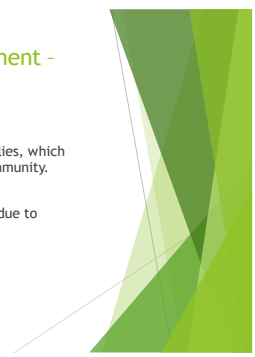
- Staff members are more likely to experience enhanced job satisfaction.
- Staff will have tools and resources to address the various aspects of pain management to enhance quality of care.



A Comprehensive Pain Management – Advancing Excellence

How Does Pain Management Benefit Nursing Homes?

- Nursing homes have satisfied residents and families, which translates into better care and image in the community.
- Nursing homes have improved Quality Measures due to improved resident care and satisfaction results.



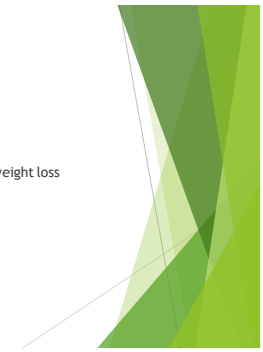
Signs of Pain

- Increased blood pressure
- Increased respiratory rate
- Tachycardia
- Diaphoresis
- Dilated pupils
- Agitation/physical movements/vocalizations

Other Signs of Pain

Severely Cognitively Impaired

- Listless
- Decreased appetite/loss of taste for food/weight loss
- Constipation
- Sleep Disturbance
- Social withdrawal
- Psychological impairment
- Function impairment and disability



Other Signs of Pain

- Agitation and Anxiety
- Verbalizations including the nonsensical
- Agitated movements
- Increased depression and anxiety
- Refusal of care
- Defensive behaviors
- Overwhelming self-focus
- Preoccupation with physical status

Adverse Effects of Untreated and Undertreated Pain

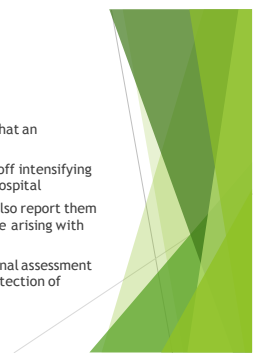
- Negative health impact and quality of life
- Slowed rehab
- Increased depression
- Increased anxiety and social isolation
- Increased immobility, gait disturbances
- Spiritual despair
- Disease progression
- Increased pain sensitivity
- Increased health care utilization and costs

Vital Signs Checks

- Temperature
- Blood pressure
- Respiration rate
- O2 saturation
- Heart rate or Pulse
- Pain
- Shortness of breath

Vital Signs

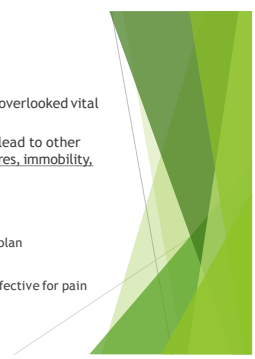
- Abnormal vital signs could be the first warning that an impending medical decline may be occurring
- Early detection and then treatment could ward off intensifying symptoms and possible transport/admission to hospital
- Nursing monitors vital signs, but therapy could also report them and be an added watchdog for issues that may be arising with the resident
- The vital sign check along with therapy's functional assessment during treatment could really help with early detection of issues



Vital Signs

Pain: considered to be an important but often overlooked vital sign in adults

- It can greatly impair a person's function and lead to other medical issues such as depression, contractures, immobility, sleep deprivation, and wounds.
- Should be assessed at:
  - Admission and Quarterly with nursing review
  - Each shift if pain management is part of care plan
  - If change is noted during review
  - When intervention is implemented to see if effective for pain reduction



Vital Signs

Dyspnea- Shortness of Breath

- It is normal with heavy exertion, but it is abnormal if it occurs with everyday functions
- It can indicate problems with pain, asthma, pneumonia, cardiac ischemia, lung disease, congestive heart failure, acute MI, COPD, and panic or anxiety disorders
- It is important to report this to nursing/physician timely
- Assess the intensity with any distinct sensation such as (effort, chest tightness, and air hunger) distress involved and impact on daily functions

Pain and Dementia

- There are an estimated 35 million people with dementia across the world. Currently, 5% of people over 65 years old have a diagnosis of dementia, rising to over 50% in those aged over 90 years.
- Demographic changes in the coming decades and the increasingly aging population will lead to a substantial growth in the number of people affected, and in the scale of the challenge associated with providing treatment and care. Pain presents a particular challenge in the treatment of dementia.

Pain and Dementia

The prevalence of pain, particularly, is strongly related to age, hitting the oldest population the hardest with prevalence rates of 72% above the age of 85 years. Given these circumstances, it is clear that pain is probably very common among people with dementia; nevertheless, current knowledge is poor which frequently leads to inappropriate treatment and care.

(Achterberg et al, 2013)

Research Concerning Pain and Dementia scales

The study examined the various assessment tools available to caregivers, leading them to conclude "current evidence on validation and clinical utility of the tools is insufficient."

Lichtner et al.; licensee BioMed Central. 2015

The Importance of Staging

Because Dementia affects many areas of function at different rates depending on what stage of the disease a person exists, it is important to understand what to expect for each stage and modify approaches or treatment to gain as much success/independence when pain is a factor

The Importance of Staging

- Provides basis for caregiver education, strategies, approaches in developing patient-centered plan of care
- Helps staff/family provide quality care while focusing on preserved abilities, not limitations

Methods of Staging

Accepted Scales

- NCCDP – 3 stages
- Global Deterioration Scale – 7 stages
- Allen Cognitive Levels – 6 levels:
  - 3 Components
    - Attention
    - Motor Control
    - Verbal Performance

Beyond Staging..

- Cognitive Testing: Provides basis for patient status and explores most preserved abilities
  - Can guide nursing towards to most beneficial pain scale/test to complete based upon those abilities.
  - Should be done to set tone for dementia programming as well

Cognitive Assessments

- Brief Cognitive Rating Scale (in conjunction with GDS)
- Allen Cognitive Level Screen
- ACL Leather Lacing or Placement Tests
- Clock Drawing
- Mini-Mental Status Exam (MMSE)
- Ross Information Processing Assessment-G (RIPA-G)
- Arizona Battery of Communication in Dementia (ABCD)
- Functional Linguistic Communication Inventory (FLCI)

Pain Assessment

- Pain Scales- used to show changes (good or bad) with any intervention and to establish a baseline
  - Numeric Rating Scale
  - Wong-Baker Faces Pain Scale
  - Visual Analog Scale
  - Pain Thermometer Scale
  - Comprehensive Pain Assessment-cognitively intact
  - PAINAD – Good tool for dementia residents
  - Pain Drawing

Pain Assessment

Pain Scales

- Brief Pain Inventory
- Initial Pain Assessment Tool
- Memorial Pain Assessment Card- includes Mood and Relief Scales
- Patient Comfort Assessment Guide

Pain Scale for Dementia

PAINAD (Pain Assessment in Advanced Dementia)

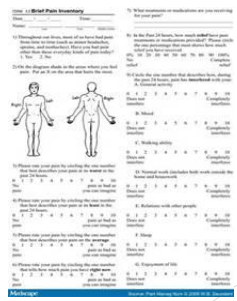
- Pain Assessment in Advanced Dementia (PAINAD) scale refers to five behavior domains that can be scored from 0 through 2. These domain scores are then added to get a total score up to 10. Staff should be aware that these non-verbal behavioral symptoms may indicate something other than pain (e.g., delirium) and a thorough pain assessment and examination should be completed

PAINAD

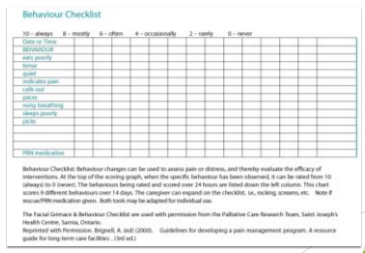
Pain Assessment IN Advanced Dementia PAINAD

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
				TOTAL

Brief Pain Inventory

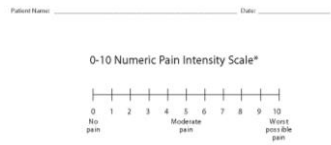


Behavior Checklist



Assessment Tools

- Numeric Rating Scale (NRS)- Patient rates pain on scale 0-10, 0= no pain and 10= worst pain imagined
  - Assess initially, following treatment and periodically as needed


Patient Name: _____ Date: _____

0-10 Numeric Pain Intensity Scale*

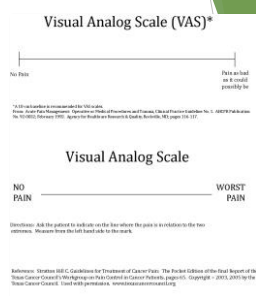
0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst possible pain

*If used as a graphic rating scale, a 10-cm baseline is recommended.
From Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032. February 1992. Agency for Healthcare Research & Quality, Rockville, MD. pages 116-117.

Assessment Tools

- Visual Analog Scale (VAS)- 10 cm line with one end marked with no pain and other end worst pain imaginable
- Patient draws line to mark intensity of pain
- Clinician measures the line and assigns a score


Visual Analog Scale (VAS)*

No Pain — Pain as bad as it could possibly be

*A 10-cm baseline is recommended for VAS scales.
From: Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline No. 1. AHCPR Publication No. 92-0032, February 1992. Agency for Healthcare Research & Quality, Rockville, MD, pages 116-117.

Visual Analog Scale

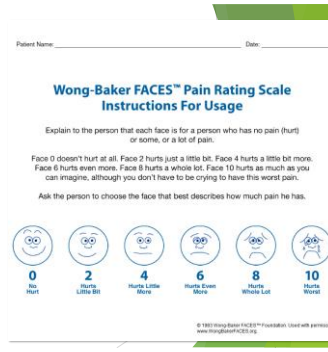
NO PAIN _____ WORST PAIN

Directions: Ask the patient to indicate on the line where the pain is in relation to the two extremes. Measure from the left hand side to the mark.

References: Stratton MAC. Guidelines for Treatment of Cancer Pain. The Pocket Edition of the final Report of the Texas Cancer Council's Workgroup on Pain Control in Cancer Patients, pages 65. Copyright © 2003, 2005 by the Texas Cancer Council. Used with permission. www.painmeasurement.org

Assessment Tools

- Wong-Baker Faces Rating Scale- visual descriptors with faces of varying expressions of distress
- The patient selects the face that describes their current level of pain


Patient Name: _____ Date: _____

Wong-Baker FACES™ Pain Rating Scale
Instructions For Usage

Explain to the person that each face is for a person who has no pain (hurt) or some, or a lot of pain.

Face 0 doesn't hurt at all. Face 2 hurts just a little bit. Face 4 hurts a little bit more. Face 6 hurts even more. Face 8 hurts a whole lot. Face 10 hurts as much as you can imagine, although you don't have to be crying to have this worst pain.

Ask the person to choose the face that best describes how much pain he has.

0 No Hurt — 2 Hurts Little Bit — 4 Hurts Little More — 6 Hurts Even More — 8 Hurts Whole Lot — 10 Hurts Worst

© 1983 Wong-Baker FACES™ Foundation. Used with permission.
www.WongBakerFACES.org

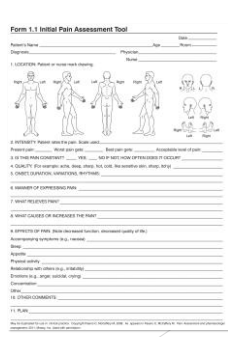
Assessing Pain

- Pain is often overlooked in the resident.
- Difficult to identify specific cause of pain. There may be many factors to ensure alignment with the mission and vision of the nursing home.
- Identification of pain can lead to improved health and quality of life.
- Provides opportunities for continuous improvement.

Challenges of Assessing Pain

- Pain is complex and multi-factorial
- Identifying causes may be difficult
- Often subtle and non-specific
- Referred pain can be misleading
- Subjective vs. objective mismatches

Core Principles of Pain Assessment and Management


Form 1.1 Initial Pain Assessment Tool

Assessment Challenges in the Elderly Population

- Under-reporting of discomfort due to fear, cultural factors or acceptance
- Impairments such as loss in hearing and vision, comprehension or verbal skills
- Difficulty with assessment tools due to visual or cognitive deficits

Comprehensive Pain Management

Pain management moves beyond traditional nursing focus, incorporates all staff (clinical, non clinical, and management)

- Similar to a focus on "Improved Dementia Care"
  - Music and Memory
- Large focus on non-pharmacological treatments
- Focus on pain indicators especially in dementia population
- Pain Management for short stay/rehab patients
- Focus on Pre-admission assessment of pain
- Focus on use of vital signs as a monitoring and assessment tool.

Challenges With Pain Management

- Lack of knowledge with pain indicators and approaches
- Time/Support constraints
- Communication demand with patient, family, nursing aides, therapy
- Non familiarity of non-pharmacological treatments
- Dementia related programming constraints
- Traditional pharmacological treatments including adverse effects like addiction

Evaluate Your Current Pain Management Program

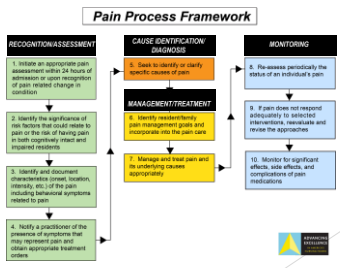
including:

- Facility competence/education
- Dementia care programming
- Use of non-pharmacological treatments
- Current tools/policies (Evidence Based/Standards of Practice)

Evaluate Your Current Pain Management Program

- Identifying deficits and areas needing improvement
- Has pain management been a QAPI focus?
  - Explore options for help (Advancing Excellence)

Advancing Excellence



Structure to Pain Management Program

- Whole house education for pain indicators and the importance of pain management
- Staff competency for direct care providers – See checklist
- Consistent vital sign checks per shift- make it part of everyone's daily routine
- Have pre-admission survey to determine pain patterns, review medications and identify risk issues through root cause analysis
- Weekly review of at risks patients with daily communication with any residents on target list
- Involve patient and family with goal setting and education

Structure of Pain Management Program

- Good communication and documentation of changes/progress with resident by IDT members
- Therapy modalities available to address pain in non-invasive or non-pharmacological ways
- Tracking system in place to determine effectiveness of interventions, progress toward goals and functional outcomes
- Continued education to caregivers to maintain resident at most pain free and functional level

Facility Education

- Include all levels of staff
  - Administration
  - Dietary/Housekeeping
  - Therapy
  - Family
- Include printed materials
- Establish competency testing for aides/therapy, etc.
- Appoint pain management expert of coordinator
- Education with Vital Signs/Pain Indicators/Approaches

Education


STAFF COMPETENCY: PAIN INDICATORS/APPROACHES

PREMIER

Name: _____

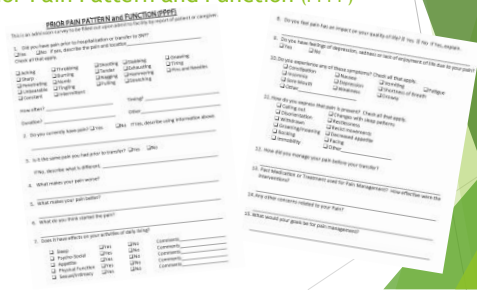
Pain Indicators and Approaches	Education	Hands-on/Practical training	Comments
Understand indicators for pain			
Facial expressions			
Verbal expressions			
Behavioral expressions			
Understands importance of Medication			
Understands importance of nutrition/hydration			
Splinting			
Understands different purposes of pain			
Understands importance of communication to			
Ability to identify changes in condition of resident			
Acts in timely manner in response or change in			
Understands impact on cognitive function			
Understands general approaches to pain relief			
Types of educational pain interventions			
Be aware of impact on routine changes due to			
Bowel and Bladder			
Nutrition and hydration			
Sleep Patterns			
Assess all pain symptoms with non communicative			
Dementia Behavior Patterns			

Trainer Signature: _____ Date: _____

Pre-Admission Survey for Pain

- Need to complete survey during admission process to gauge residents pain pattern, functional level, prior interventions and at risk issues
- Admission Coordinator will utilize Prior Pain Pattern and Function(PPPF) Survey during admission process to interview resident or caregivers

Prior Pain Pattern and Function (PPPF)


PRIOR PAIN PATTERN and FUNCTION (PPPF)

PPPF Survey

You will be able to determine:

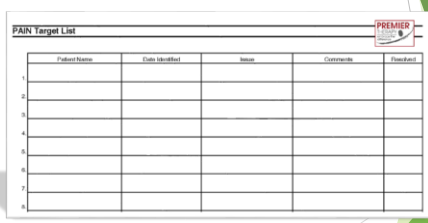
- if the resident had pain prior to coming to your facility
- what the pain feels like and when it occurs
- what makes the pain worse and what helps relieve the pain
- what may be the cause of the pain
- how the pain affects activities and function throughout day including appetite and sleep
- determine if resident is dealing with psychosocial issues
- how the resident communicates that they have pain (especially if non-communicative)

PPPF Survey

You will be able to determine:

- what medications are they presently on and how much
- do the medications help with relief of pain
- what are the resident's goals in relation to pain management

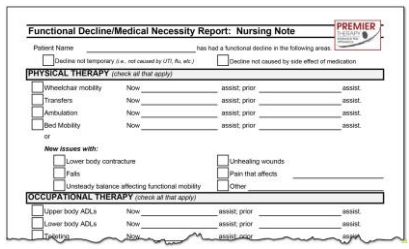
Target List and Weekly Review


PAIN Target List

PREMIER

	Patient Name	Date Identified	Issue	Comments	Resolved
1					
2					
3					
4					
5					
6					
7					
8					

Communication/Documentation of Pain



Functional Decline/Medical Necessity Report: Nursing Note

PREMIER THERAPY

Patient Name _____ has had a functional decline in the following areas.

☐ Decline not temporary (i.e., not caused by UTI, flu, etc.) ☐ Decline not caused by side effect of medication

PHYSICAL THERAPY *(check all that apply)*

☐ Wheelchair mobility Now _____ assist; prior _____ assist.
☐ Transfers Now _____ assist; prior _____ assist.
☐ Ambulation Now _____ assist; prior _____ assist.
☐ Bed Mobility Now _____ assist; prior _____ assist.

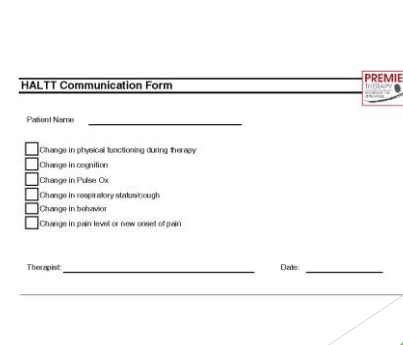
or

New issues with:

☐ Lower body contracture ☐ Unhealing wounds
☐ Falls ☐ Pain that affects _____
☐ Unsteady balance affecting functional mobility ☐ Other _____

OCCUPATIONAL THERAPY *(check all that apply)*

☐ Upper body ADLs Now _____ assist; prior _____ assist.
☐ Lower body ADLs Now _____ assist; prior _____ assist.
☐ Feeding Now _____ assist; prior _____ assist.



HALTT Communication Form

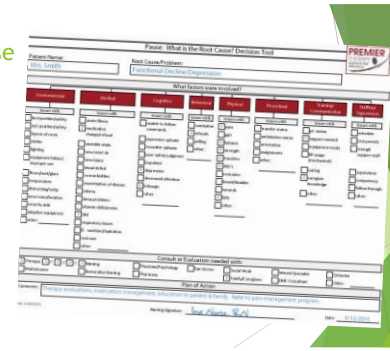
PREMIER THERAPY

Patient Name _____

☐ Change in physical functioning during therapy
☐ Change in cognition
☐ Change in Pulse Ox
☐ Change in respiratory status/cough
☐ Change in behavior
☐ Change in pain level or new onset of pain

Therapist: _____ Date: _____

Root Cause Analysis



Pause: What is the Root Cause? Decision Tool

PREMIER THERAPY

Patient Name: (Mrs. Smith)

Root Cause/Problem: Functional Decline/Depression

What factors were involved?

Communication | Medical | Cognition | Behavioral | Physical | Psychosocial | Spiritual/Cultural | Contextual

Consult or Evaluation needed with:

Plan of Action: Develop medication management, education to patient & family, Refer to pain/depression program

Nursing Signature: Jane Alliance, RN

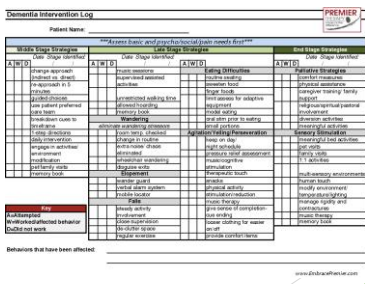
Date: 8/12/2004

Therapy Non Pharmacological Intervention

- Therapy Tools
  - Comprehensive evaluation using standardized Pain Scales (can determine root cause)
  - Use of modalities (e-stim, including iontophoresis; ultrasound, including phonophoresis; diathermy)
  - Adaptive equipment (splinting, positioning tools, AFOs, pressure relief modes)
  - Treatment techniques (contract/relax techniques, icing, traction, manual therapy (muscle bending/cross friction massage)

Tracking Progress and Outcomes for Pain

Dementia Intervention Log



Functional Outcomes Tracking

- Quality Measure: Percentage of short-stay residents who made improvements in function (MDS-based)
- Functional Outcomes Measures (Patient specific)

  MDS: Section G, GG, J, among others

  Therapy Software Outcomes: Functional Outcomes Systems, Functional Independence Measures – tracked per skill set.

Where Do We Go From Here?

- ✓ Assess current pain management program and establish goals were improvement is needed (QAPI)
- ✓ Assign a pain management coordinator
- ✓ Whole house education with competencies in both pain indicators, vital signs, and the importance of communication
- ✓ Complete Sensory and dementia assessments
- ✓ Make sure that patient driven assessment tools are available
- ✓ Establish a tracking system for interventions/outcomes
- ✓ Continue with Nursing monitoring, make appropriate assessments and referrals as needed

Course Objectives Review

1. Attendees will be able to explain and describe pain assessments for a variety of diagnoses.
2. Attendee will be able to explain how pain affects most Quality Measures.
3. Attendee will be able to describe a comprehensive pain management program that enhances quality of life of resident and decreases burden of caregivers.

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