Pain Careplans and Monitoring: Role of the Interprofessional Team

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Disclosures

- I have no relevant disclosures

LTC: Review Current Careplanning Guidance § 483.20

- **Resident assessment.**
- The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.
- **(a)*Admission orders.*** At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

Comprehensive Care Plan

- A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
- **(i)** Identification and demographic information.
- **(ii)** Customary routine.
- **(iii)** Cognitive patterns.
- **(iv)** Communication.
- **(v)** Vision.
- **(vi)** Mood and behavior patterns.
- **(vii)** Psychosocial well-being.
- **(viii)** Physical functioning and structural problems.
- **(ix)** Continence.
- **(x)** Disease diagnoses and health conditions.
- **(xi)** Dental and nutritional status.
- **(xii**) Skin condition
- **(xiii)** Activity pursuit.
- **(xiv)** Medications.
- **(xv)** Special treatments and procedures.
- **(xvi)** Discharge planning.
- **(xvii)** Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
- **(xviii)** Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

Resident Involvement

- **F553 §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:**
- **(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.**
- **(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.**
- **(iii) The right to be informed, in advance, of changes to the plan of care.**
- **(iv) The right to receive the services and/or items included in the plan of care.**
- **(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.**

Baseline Care Plan

- ***§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must—***
- ***(i) Be developed within 48 hours of a resident's admission.***
- ***(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—***
- ***(A) Initial goals based on admission orders.***
- ***(B) Physician orders.***
- ***(C) Dietary orders.***
- ***(D) Therapy services.***
- ***(E) Social services.***
- ***(F) PASARR recommendation, if applicable.***

- ***§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan—***
- ***(i) Is developed within 48 hours of the resident's admission.***
- ***(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).***

- ***§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:***
- ***(i) The initial goals of the resident.***
- ***(ii) A summary of the resident's medications and dietary instructions.***
- ***(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.***
- ***(iv) Any updated information based on the details of the comprehensive care plan, as necessary.***

Care Planning

INTENT §483.21(a)

- Completion and implementation of the baseline care plan within 48 hours of a resident's admission is **intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.**

Care Planning in Other Settings

- In AL pain management is incorporated into the Service Plan.
  - State by state differences in the service plan and not national regulations.

Care Planning in Primary Care and at Home

- Patient goals
  - What are the patient expectations with regard to pain
  - What are their goals?
    - Is it realistic to have NO pain
    - What is their experience/thoughts re pharm and non pharm interventions

Pain Assessment

- Pain is a subjective symptom and those who are cognitively able can identify pain and report it and ??? measure it.
- Approximately 30-50% of individuals with dementia experience pain and the pain often presents in behaviors such as aggression, agitation, withdrawal, confusion, impaired or worsening of function.

Pain Assessment

- We need tools to evaluate / measure pain in those with and without cognitive impairment
  - The Verbal Descriptor Scale (VDS) is a useful way to evaluate subjective pain…better than 1-10!
    - The VDS focuses on pain that is occurring at the time of testing and consists of a series of phrases that represent different levels of pain intensity (e.g., “no pain,” “mild pain,” “moderate pain,” “severe pain,” “extreme pain,” and “the most intense pain imaginable”)
    - The VDS was noted to be feasible to complete and to have sufficient evidence of reliability and validity when used with older adults, including those with moderate dementia.

Reference: Herr K. Pain assessment strategies in older patients. Journal of Pain 2011;12(3 Suppl 1):S3-S13.

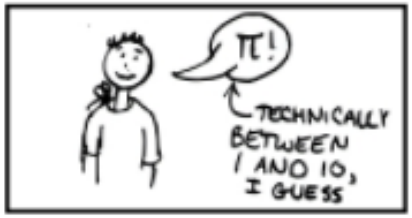
"WHAT IS YOUR PAIN LEVEL ON A SCALE OF 1 TO 10?"
UNACCEPTABLE ANSWERS:

FLAGRANT DISREGARD FOR 10 POINT SCALE

ABSOLUTE REFUSAL TO GIVE A NUMBER

NUMBER PROVIDED FOR EVERY ACTIVITY YOU CAN THINK OF

AN IRRATIONAL NUMBER



AN IMAGINARY NUMBER

Pain Assessment

- For those with cognitive impairment the Pain Assessment in Advanced Dementia (PAINAD) is a useful way to evaluate pain objectively.
  - The PAINAD includes 5 behaviors that are commonly noted among individuals with pain.
  - Observations should be done during periods of activity such as transferring or ambulating.
  - Scoring ranges from 0 to 2 for each specific pain behavior. A total score of 1-3 is indicative of mild pain, 4-6 is moderate pain and 7-10 is severe pain.

Reference: Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) Scale. Journal of the American Medical Directors Association. 2003;4(1):9-15.

The Verbal Descriptor Scale

1. Are you experiencing any pain right now?

1=Yes 0=No

If resident answers ‘ no’ to question 1, code answer and continue with question 3. If resident answers yes ask:

2. What one word best describes your pain:

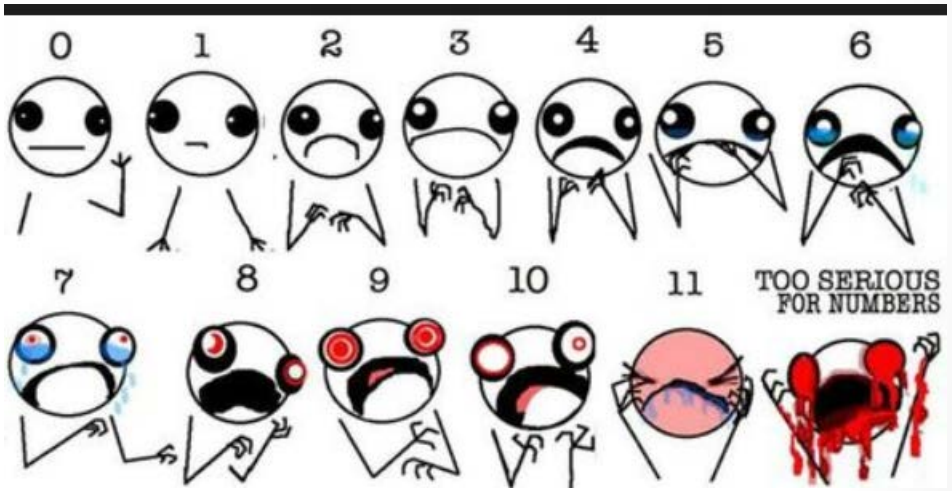
1=None
2=Mild
3=Discomforting
4=Distressing
5=Horrible
6=Excruciating

Behavior	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional laboured breathing, short period of hyperventilation	Noisy labored breathing, long period of hyperventilation, Cheyne-Stokes respirations	
Negative vocalization	None	Occasional moan of groan, low-level speech with a negative or disapproving quality	Repeated troubled calling out, loud moaning or groaning, crying	
Facial expression	Smiling or inexpensive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense, distresses 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	

Pain Assessment in Advanced Dementia (PAINAD) *

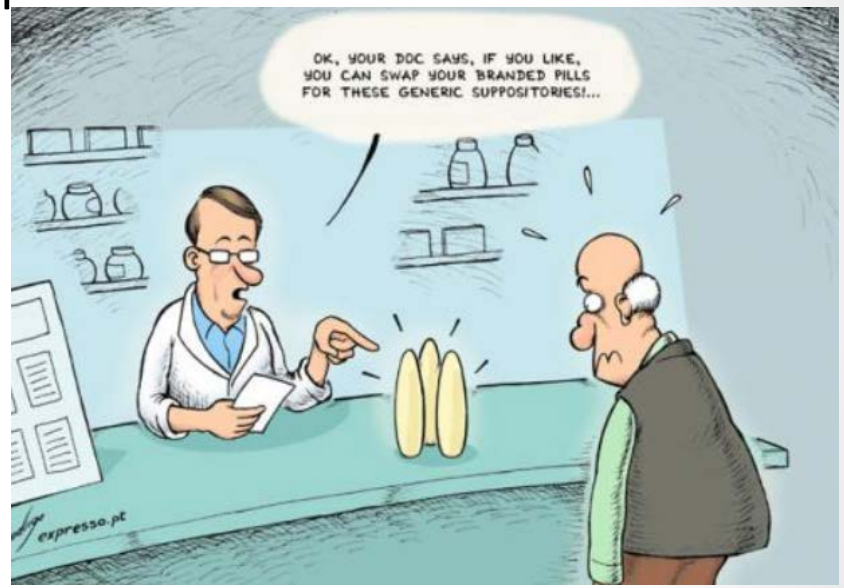
*Scoring: The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain.


I CAN'T
STAND IT!


0
1
2
3
4
5
6
7
8
9
10
11
TOO SERIOUS
FOR NUMBERS

Care Planning PAIN

- IPE Care Planning and opportunity to incorporate behavioral and pharmacologic management of pain.
  - Positioning
  - Physical Activity
  - Ice/heat and local treatment
  - Music/distraction
  - Drugs-consider local ointments
  - Others?



Care Plan Forms for LTC setting (NH)

- See handout for a full care plan form
- Adapted from American Association of Directors of Nursing Services

Once Developed ….Transition to A Useable SNAPSHOT

- Get the careplan into the hands of those providing care
- Work with the facility to find a location that will be easily accessible and HIPPA compliant so that this information can be used.

Care Plan Snapshot

Care Goals	**Short term goal #1: Resident will report that back pain is maintained within the 0-5 range on a 0-10 point scale.** **Short term goal #2: Resident will be able to participate in activities and meals as desired.** **Long term goal: Resident will show an increase in expressions of wellbeing (smiling, laughing, engaging in activities) and a decrease in expressions of pain and distress (agitation, restlessness, wandering and apathy).**

Care Area	Resident Responsibilities	Staff Responsibilities
Heat to back is provided at least three times per day for 15 minutes.	Resident will be willing to receive heat treatment when it is provided	Staff to provide a hot pack with moist heat at a time that works mutually for the staff and the resident.
Icy-hot to back will be provide 3 times per day.	Resident will be willing to receive icy-hot to back 3 times per day between heat treatments.	Resident will provide icy-hot to back 3 times per day between heat treatments.
Acetaminophen 1000 mg tid for pain.	Resident will be willing to take acetaminophen tid for pain	Staff will provide acetaminophen tid for pain.
Distraction	Resident will attend activities during the day and evening as offered.	Staff will remind and encourage resident to attend activities and facilitate getting her to these activities.

Behavioral Issues: Restlessness, agitation; occasionally engages in disruptive vocalizations when she is in pain

Related to: Pain

Approaches by staff:

- **Assess for pain exacerbation when signs are noted that may be due to pain**
- **Engage resident in distraction as much as possible**
- **Provide consistency in care using same caregivers when possible and consistent approaches to pain management.**
- **Respond calmly to resident during times of acute exacerbation of pain and assure the resident that the pain will be managed.**

Pain Management Tidbits for AL

- As noted Pain management is incorporated into the service plan
  - Must avoid use of prn medications (state by state variation on who can assess the patient need for medication).
  - Focus on prevention of pain in the careplan.

Motivating Staff or Caregivers/Residents to Utilize the Careplan

- Self-efficacy based approach
  - Performance of the behavior…if it is useful it will stick and if not re evaluate
  - Verbal encouragement to JUST DO IT..JUST TRY IT
  - Role modeling
  - Elimination of unpleasant sensations

Ongoing Evaluation and Re-Evaluation

- Most settings have some type of weekly / daily report
  - Review adherence to snapshot careplans…review resident status based on the careplan (not just new acute medical problems!)
  - Review weekly and re-evaluate and revise the careplan if needed.
  - Document response
  - REINFORCE adherence to the careplan by staff and residents.

Ongoing Evaluation and Re-Evaluation

- Monthly pain rounds
  - Meet monthly and review pain of all residents in which this is part of their careplan.
  - Get feedback from staff in terms of what they are doing (i.e., hold staff accountable for careplan related activities).
  - Provide positive reinforcement to implementing careplan related activities.
  - Document resident involvement in careplan activities

Primary Care Pain/Patient Follow Up

- Critical to evaluate pain at every patient encounter
- Try and try again
  - Incorporate behavioral and pharm approaches
  - BELIEVE in the benefit of the approach
  - NEVER….say there is nothing more that can be done.
  - Be innovative in approach
    - Take a person centered perspective-what the individual enjoys that may serve as a distraction; what is realistic and doable; what may or may not be evidence based…..placebos have been noted to be effective.