the Remedi Pulse

PAIN MANAGEMENT

Remedi SeniorCare EDUCATION Rx

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

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Survey Solutions

with William Vaughan, BSN, RN VP of Education & Clinical Affairs

Pain Management: Opinions from the Bench

In the November 2015 issue of the Remedi Pulse, we reviewed various pain management concepts which when implemented, frequently result in improved clinical outcomes for residents and lessen regulatory risk for facilities. We end 2015 by taking a look at two administrative law decisions focusing on deficiencies in nursing homes related to pain management. The source for these rulings is the Departmental Appeals Board, a federal agency housed in the Department of Health and Human Services. Nursing homes wishing to formally dispute federal deficiencies, which prompted a sanction (civil money penalty, loss of nurse aide training program, etc.) have a right to do so in front of an administrative law judge. While the rulings are summarized below, you can read them in their entirety at http://www.hhs.gov/dab/decisions/index.html:

- The Green House Cottages of Southern Hills (Decision No. CR3437 Date: October 28, 2014): During the evening of September 10, 2013, a surveyor observed a resident "complaining of pain during and immediately after the staff's attempt to move him." Approximately one hour later, the nursing staff administered the medication Loratab to the resident rather than Lorcet-10, which was currently ordered for pain as needed. According to the judge, "… the staff did not give the resident the medication for over an hour when the resident complained of pain on September 10, and when they eventually did, it was not the proper amount of pain medication that the physician had prescribed … The physician's order allowed no room for the staff to substitute their judgment for that of the physician and to give the resident something other than precisely what had been ordered." The deficiency was upheld

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FOR MORE INFORMATION

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The Basics of Pain Assessment

Prepared by: Rebecca Ogden, BSN, RN, CRNI, Corporate Account Manager

Pain recognition is a challenge in the long-term care setting. Determining severity can be difficult as pain is subjective and can be difficult to express. Developing a systematic approach to assess pain is essential. In order to properly evaluate residents and provide appropriate treatment, pain should be routinely assessed, reassessed, monitored, evaluated, and clearly documented.

1 - RESIDENT'S SELF-REPORT

Most accurate and reliable evidence of the presence and intensity of pain

- Frequency
  - » Constant or intermittent
  - » Regular or sporadic occurrence
- Location
  - » Internal or external
  - » Local or diffuse
- Description
  - » Sharp
  - » Aching
  - » Burning/on fire sensation
  - » Tingling/pins and needles sensation
  - » Electric shock sensation
  - » Tight
  - » Pulling
  - » Stabbing or cutting
  - » Twisting
  - » Shooting
  - » Throbbing
- Measures that relieve or heighten the pain
  - » Heat, cold, massage, or drugs
  - » Lying down, rather than sitting or vice-versa
  - » What has been used in the past- pain better or worse
- Mild to moderately cognitively impaired residents may be able to use pain intensity scales (e.g., 0-10, mild-moderate-severe, Wong-Baker FACES, etc.)
- If resident is unable to self-report or use a pain intensity scale, use a reliable and valid nonverbal pain assessment tool (see the Remedi November 2015 Monthly Resource: Nonverbal Indicators of Pain)

2 - POTENTIAL CAUSES OF PAIN

- Pathological conditions
- Surgeries
- Activites
- Repositioning
- Procedures (e.g., wound care, lab draws, etc.)

3 - OBSERVE RESIDENT BEHAVIORS

- Functional Ability indicators (reliable and valid behavior scales can assist with these indicators)
  - Moaning, groaning, and/or crying
  - Changes in gait
- Ability to perform ADLs
- Sleep pattern
- Mood
- Cognition
- Withdrawn or agitated behavior
- Activity changes
- Pain related behaviors may not accurately reflect intensity of pain

4 - SURROGATE REPORTING OF PAIN AND BEHAVIOR/ACTIVITY CHANGES (e.g., family members, caregivers, nursing assistants, etc.)

- Subtle changes in behavior/activity
- Increased accuracy of pain assessment when combined w/clinician's observations/judgment

5 - ATTEMPT ANALGESIC TRIAL

- If pain anticipated or occurs
- If resident behaviors suggest presence of pain
- Establish analgesic regimen, if pain relief obtained and observed behavior subsides

Also consider weight loss or changes in appetite, skin color/temperature and/or vital signs as potential indicators of pain. Although not considered as primary indicators of pain (all could stem from an underlying medical conditions), these factors should still be taken into consideration when performing a thorough pain assessment.

Incorporating these basic pain assessment techniques into your nursing practice can improve your ability to recognize and treat your resident's pain.

What are Your Thoughts on Pain? Take our Truth Vs. Myth Quiz

Prepared by Jennifer Hardesty, Pharm.D., FASCP, Chief Clinical Officer

Pain is often a common symptom among our residents - whether it is pain from a joint replacement on a post-acute unit or persistent arthritic pain in a long-term resident. Untreated pain can impact residents physically, mentally, and socially in many ways - including interfering with their activities of daily living, sleep, and mobility. Pain can also lead to depression, anxiety, and other physical stresses. Many barriers to effective pain management still exist, and include challenges with staff turnover, regulatory issues with controlled substances, lack of formal pain education for staff, and cognitive impairment of residents, to name a few. Sometimes without realizing it, providers and staff may have internal beliefs or biases that can inadvertently create barriers to good a pain assessment and management program. **What do you think? Take our Truth Vs. Myth Quiz!**

This quiz, along with some basic pain education, would be a great way to educate clinical and non-clinical staff about some of the myths and misperceptions surrounding pain.

Truth Vs. Myth Quiz

1. Lying and complaining about pain are common in the elderly.

   ☐ Truth ☐ Myth

2. The nurse and physician are the best authority on the resident's pain.

   ☐ Truth ☐ Myth

3. Pain perception decreases with age, because the elderly have a higher pain threshold than younger people.

   ☐ Truth ☐ Myth

4. Pain is whatever the resident says it is, existing whenever he/she says it does.

   ☐ Truth ☐ Myth

5. Pain management is a resident's right.

   ☐ Truth ☐ Myth

6. As many as 40 - 80% of the elderly in nursing homes may suffer from pain on a daily basis.

   ☐ Truth ☐ Myth

7. Although elderly people suffer chronic pain more frequently than other populations, their pain is under-reported and under-treated.

   ☐ Truth ☐ Myth

8. A resident with pain, who watches the clock, is addicted.

   ☐ Truth ☐ Myth

9. Having pain is a natural part of getting old (or an inevitable consequence of aging).

   ☐ Truth ☐ Myth

10. Assessment of pain (type, severity, frequency, etc.,) is one of the most important factors in proper pain management.

    ☐ Truth ☐ Myth

11. Management of pain may include drug therapy or non-drug methods, such as heat or cold application, distraction, surgery, and relaxation techniques.

    ☐ Truth ☐ Myth

12. Elderly residents are usually given too much pain medicine.

    ☐ Truth ☐ Myth

13. With chronic pain, the resident should learn to live with it.

    ☐ Truth ☐ Myth

14. In the cognitively impaired elderly (e.g., dementia, Alzheimer's disease), complaints of pain are often false.

    ☐ Truth ☐ Myth

15. Uncontrolled pain can decrease the resident's functional level and impair their quality of life.

    ☐ Truth ☐ Myth

Answers on next page.

Nurse of the Month

DAWN MANN, RN, UNIT MANAGER
The Laurels of Galesburg, MI

CONGRATULATIONS to Dawn Mann, RN, Unit Manager, at The Laurels of Galesburg, MI for being chosen as the Remedi Nurse of the Month. Dawn was nominated by her administrator, Angela Keith, RN, NHA. Per Angela, "Dawn has worked at the Laurels of Galesburg mainly as a Unit Manager, but has also worked the unit as a staff nurse. She leads the nursing staff every day by positive example. With ease, Dawn is able to juggle the responsibilities of the unit manager and be very personally involved with families and the guests on her unit. She has shown great resilience through all the changes that Galesburg has been through in her four years here. Dawn has grown as a manager, and I trust that when she is here, I have little to worry about as she catches problems before they start. She has assisted in training many unit managers that were unable to bear the difficult task of being a unit manager here at The Laurels of Galesburg. If I have a special project, Dawn is always willing to come in and assist me at all hours of the day or night. She is truly a leader who leads by example."

The Remedi "Nurse of the Month" exemplifies excellence in nursing practice. Email your Nurse of the Month nomination(s) to Rebecca.Ogden@RemediRx.com. Nurses Rock!!

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as was the $2000 civil money penalty associated with it.

- Pearsall Nursing and Rehabilitation Center – North (Decision No. CR4197 Date: September 10, 2015): In January 2014, a wheelchair-bound female resident complained of pain prompting an x-ray which revealed an acute fracture of the left hip. A referral to an orthopedic surgeon was made, but due to confusion over insurance requirements, it took several weeks before she was actually seen. The administrative law judge wrote "It is undisputed that for 30 days Petitioner's staff did not arrange for or provide any care or services to address Resident 1's acute intertrochanteric fracture … nursing staff appeared to stop all active attempts at arranging the appropriate services for Resident 1, once they determined that preauthorization was needed to refer the resident to a specific orthopedic surgeon … There are no documented assessments of Resident 1's hip or her pain levels during this time, nor does there appear to be any attempt to secure even temporary care for her fracture … Petitioner's lack of any reasonable efforts to secure or attempt to provide appropriate services for Resident 1's femur fracture represents a shocking disregard of Resident 1's health and overall well-being. It is equally shocking and remarkable that Petitioner's staff undertook no assessments of Resident 1's pain, mobility, or ability to bear weight despite being fully aware that she was suffering from a fractured hip." The judge sustained the deficiency and the $8,750 civil money penalty that resulted from it.

Cases such as this illustrate that pain management remains a priority for regulators, while presenting unique challenges for facilities. Leaders in today's nursing homes should continue to structure processes that make outcomes such as those described above less likely to occur.

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.

Fentanyl Disposal Update

Per the FDA, ISMP, and manufacturer guidelines, used or discontinued unused fentanyl patches should be folded with the sticky sides together and then flushed down the toilet. If flushing is not an option, patches may be folded and then placed into a secure medication disposal container such as Drug Buster® or Rx Destroyer™. Do NOT dispose of fentanyl patches in trash receptacle or biohazard (sharps) container.

References:
Duragesic® (fentanyl transdermal system) full prescribing information. 2014. Available at http://www.duragesic.com/sites/default/files/pdf/duragesic_0.pdf

References for The Basics of Pain Assessment:

http://www.aspmn.org/documents/PainAssessmentinthePatientUnabletoSelfReport.pdf. Accessed 25Nov2015.

http://www.americannursetoday.com/questioning-common-nursing-practices-what-does-the-evidence-show/. Accessed 25Nov2015

Truth vs. Myth Quiz

Key

1) M; 2) M; 3) M; 4) T; 5) T; 6) T; 7) T; 8) M; 9) M; 10) T; 11) T; 12) M; 13) M; 14) M; 15) T