The Imperative of Evidence-Based Nursing Practice for Pain Management

Jennifer Pettis, MS, RN, CNE, WCC, Associate Director, Long-Term Care
NICHE | Nurses Improving Care for Healthsystem Elders
NYU Rory Meyers College of Nursing

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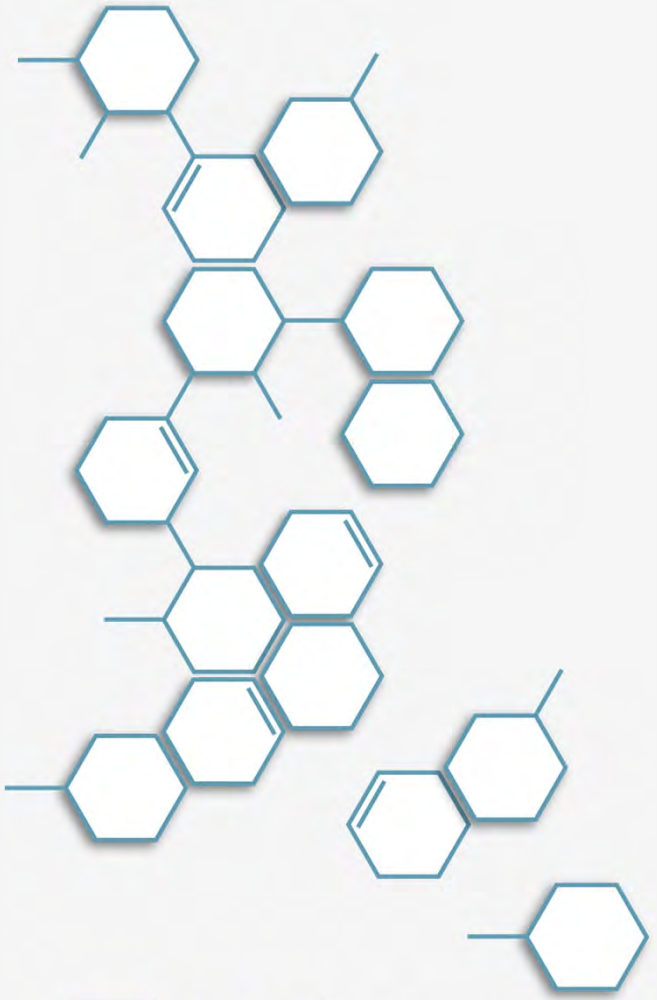

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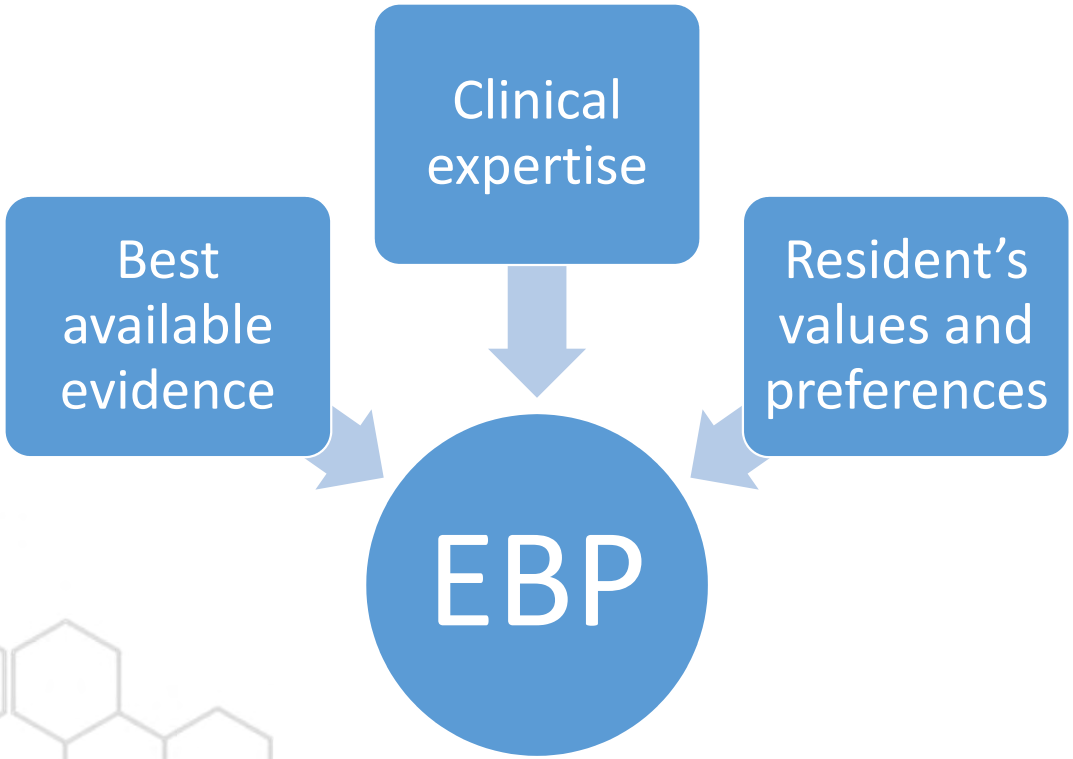
Session Objectives

- Discuss the need for evidence-based practice (EBP) in long-term care (LTC)
- List barriers to implementing EBP in LTC
- Name factors that support implementation and ongoing use of EBP in LTC
- Identify resources to support evidence-based pain assessment and management in LTC

Evidence-Based Practice (EBP) in Long-Term Care (LTC)



A Protocol by Any Other Name

- EBP: A framework for clinical practice that integrates the best available scientific evidence with the expertise of the clinician and with patients' preferences and values to make decisions about healthcare
- Protocol: Detailed guide for approaching a clinical problem or condition, tailored to a specific population
- Clinical Practice Guideline: An official recommendation or approach to diagnose and manage a broad health condition
- Algorithm: Set of steps that approximates the decision process of an expert clinician

The Population-Based Case for EBP in LTC

- By 2060 the US population will include:
  - 98 million people ages 65 and older
  - 20 million people age 85 and older
  - More than 600,000 centenarians
- Older adults are more diverse
- The number of older adults with chronic conditions continues to increase
- Long-term care utilization will likely double by 2050

The Regulatory Case for EBP in LTC

- F658 §483.21(b)(3) Comprehensive Care Plans
- The services provided or arranged by the facility must be consistent with the comprehensive care plan, must—
  - (i)Meet professional standards of quality

The Quality Case for EBP in LTC

- Higher acuity resident population
- Increased admissions and discharges
- Consumer, regulator, and payer expectations around quality and safety
- Blurred scope of practice lines between LPNs and RNs

Barriers to Implementing EBP in LTC

- Staff-level barriers:
  - Attitudes and misunderstandings
  - Lack of knowledge
  - Poor communication
- Organization-level barriers:
  - Lack of champion(s)
  - Poor physician engagement
  - Absence of policies that ensure compliance with EBP
- Consumer-level barriers:
  - Resident beliefs and attitudes
  - Family beliefs and attitudes

Factors that Support Implementation and Ongoing Use of EBP in LTC

- Education
- Accountability of providers and staff
- Shared decision making
- Availability of a nurse expert
- Professional characteristics
- Time for implementation

The Case for Evidence-Based Pain Management in LTC

- Prevalence of persistent pain:
  - Community-dwelling older adults: 25% to 76%
  - Nursing home residents: 83% to 93%
- Older adults often have multiple:
  - Chronic conditions
  - Types of pain
  - Causes of pain

The Case for Evidence-Based Pain Management in LTC (cont.)

- Pain is associated with:
- Depression
- Withdrawal and decreased socialization
- Sleep disturbances
- Functional loss and increased dependency
- Exacerbation of cognitive impairment
- Increased healthcare utilization and costs

Let’s Chat

- Consider your care protocols surrounding pain assessment and management for a moment.
- What evidence informed your facility’s care protocol development?

F697 §483.25(k) Pain Management

- The facility must ensure that pain management is provided to residents who require such services, consistent with:
  - Professional standards of practice
  - The comprehensive person-centered care plan
  - The residents' goals and preferences

Try This®: Assessing Pain in Older Adults

- Includes three scales:
  - The Faces Pain Scale – Revised
  - The Numeric Rating Scale
  - The Verbal Descriptor Scale

- Available from: https://consultgeri.org/try-this/general-assessment/issue-7.pdf

A Multi-faceted Approach to Assessing Cognitively Impaired Residents

- Attempt a self-report pain scale
- Assess of pain-related behaviors
- Obtain family and caregiver input
- Evaluation of changes in function and vocalizations
- Evaluate response to treatment

Tools to Assess Pain in Cognitively Impaired Individuals

- Assessment of Discomfort in Dementia Protocol (ADD)
- Checklist for Nonverbal Pain Behaviors (CNPI)
- Pain Assessment in Advanced Dementia Scale (PAIN AD)
- Doloplus 2
- Pain Assessment Scale for Seniors with Severe Dementia (PACSLAC)
- Non-Communicative Patient’s Pain Assessment Instrument (NOPPAIN)

Try This®: Assessing Pain in Older Adults with Dementia

- Pain Assessment in Advanced Dementia Scale (PAINAD) includes the following categories:
  - Breathing independent of vocalization
  - Negative vocalization
  - Facial expression
  - Body language
  - Consolability
- Available from: https://consultgeri.org/try-this/dementia/issue-d2.pdf

Pain Management

- Goal: Maximize function and quality of life

- A multimodal approach:
  - Pharmacological
  - Nonpharmacological
  - Interdisciplinary

Let’s Chat

- What nonpharmacological options to promote comfort are readily available to residents in your facility?
- How are your interdisciplinary colleagues involved in pain management?

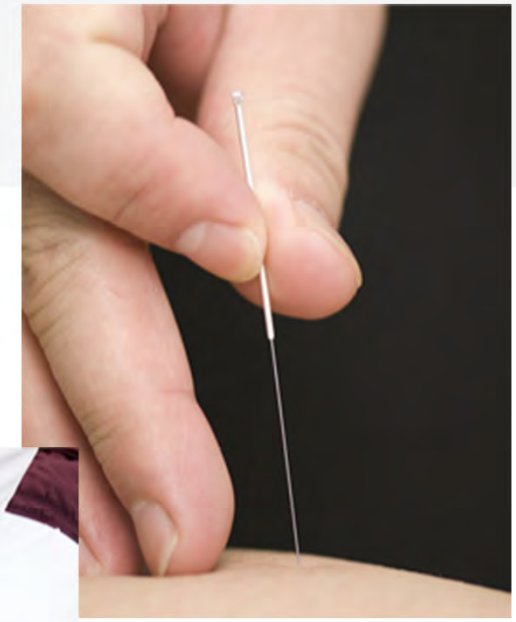
Pharmacological Treatment Considerations

- Selection and dosage
  - Low dose with gradual upward titration
  - Short half-life and fewest side effects
  - Least invasive route
- Complexity
  - Multidimensional
  - Tailored to patient
  - Combination of therapies
- Prevention
  - Around the clock (ATC) dosing
  - Dosing prior to painful treatment or event
  - Giving the next dose before last dose wears off
- Side effects
  - Proactive treatment

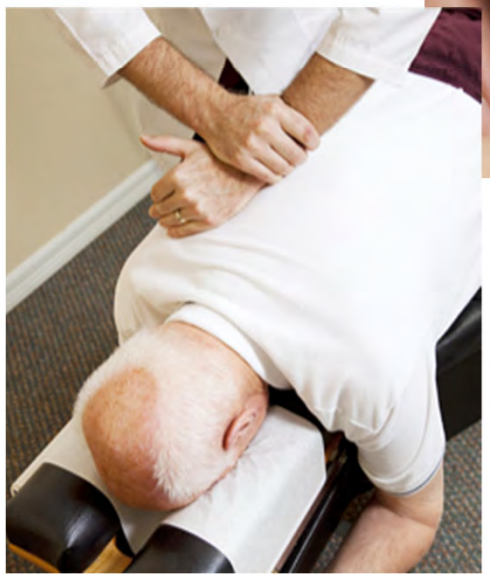
Clinical Practice Guidelines and Resources

- American Geriatrics Society
  - https://doi.org/10.1111/j.1532-5415.2009.02376.x
- The University of Iowa College of Nursing
  - https://geriatricpain.org/pain-management
- World Health Organization's Three Step Ladder for Cancer Pain
  - https://www.who.int/cancer/palliative/painladder/en/
- International Association for the Study of Pain
  - https://www.iasp-pain.org
- The City of Hope Pain and Palliative Care Resource Center
  - https://prc.coh.org
- AMDA – the Society for Post-Acute and Long-Term Care Medicine
  - https://paltc.org

Nonpharmacological Treatment Options



- Alternative medical systems
- Manipulative and body-based methods
- Mind-body interventions
- Energy therapies
- Physical pain relief modalities



Communicate and Educate

- Promote proactive use of medications
- Educate regarding medications and side effects
- Explain and offer nonpharmacological options
- Tap into interdisciplinary colleagues
- Provide pain management education to staff

Percent of Residents Who Self-Report Moderate to Severe Pain (Short Stay)

Numerator

Short-stay residents whose target assessment shows self-report of:

- **Almost constant or frequent pain and at least one episode of moderate to severe pain AND/OR**
- **Very severe/horrible pain of any frequency**

Denominator

All short-stay residents with a selected target assessment, except those with exclusions.

Exclusions

- The pain interview is not completed
- Missing data in J0300 through J0600

Percent of Residents Who Self-Report Moderate to Severe Pain (Long Stay)

Numerator

Long-stay residents whose target assessment shows self-report of:

- **Almost constant or frequent pain and at least one episode of moderate to severe pain AND/OR**
- **Very severe/horrible pain of any frequency**

Denominator

All long-stay residents with a selected target assessment, except those with exclusions.

Exclusions

- The target assessment is an admission assessment, a 5-day PPS assessment, or a Medicare Readmission/return assessment
- The pain interview is not completed
- Missing data in J0300 through J0600

Covariate

- Independence or modified independence in daily decision making on the prior assessment

What About Opioids?

- May negatively impact quality measures:
  - Bladder and bowel incontinence
  - Falls
  - Decreased ability to perform activities of daily living
  - Others
- Can lead to adverse drug events
- Concerns about the opioid epidemic and drug diversion

Lessons Learned from atom Alliance: Five Steps to Success

1. Review all current opioid orders
2. Identify source(s) of pain
3. Check for accuracy during care transitions
4. Reduce unnecessary opioid prescriptions
5. Replace opioids with appropriate alternatives

Lessons Learned from atom Alliance: Comfort Menu

- Sleep (e.g., warm bath, music, sound machine)
- Relaxation (e.g., stress ball, Snoezelen room)
- Entertainment (e.g., reading or talking visit, magazines, books)
- Feeling better (e.g., chocolate, grooming options, deep breathing, pastor visit)
- Comfort (e.g., warm blanket, lip balm, ice pack, hand-held muscle massager)

Centers for Medicare & Medicaid Services Adverse Drug Event Trigger Tool

Adverse Drug Event Trigger Tool

Adverse Drug Event (ADE)	**Risk Factors** - These increase the potential for ADEs. Multiple factors increase risk.	**Triggers: Signs and Symptoms (S/S)** - Any of these may indicate an ADE may have occurred.	**Triggers: Clinical Interventions** - These actions may indicate an ADE occurred.	**Surveyor Probes** - These questions are designed to assist in the investigation. A negative answer does not necessarily indicate noncompliance.

Change in mental status/delirium related to opioid use	• PRN or routine use of opioid medication
	• Opioid naiveté (someone who has not been taking opioids)
	• History of opioid abuse
	• Opioid tolerance
	• Severe pain
	• Low fluid intake/dehydration
	• Low body weight
	• History of head injury, traumatic brain injury, or seizures
		• Falls
		• Hallucinations
		• Delusions
		• Disorientation or confusion
		• Anxiety
		• Unresponsiveness
		• Decreased
		  • BP
		  • Pulse
		  • Pulse oximetry
		  • Respirations
			• Administration of Narcan
			• Transfer to hospital
			• Call to physician regarding new onset of relevant signs or
				• Is there an assessment and determination of pain etiology?
				• Does the resident's pain management regime address the underlying etiology?
				• For a change in mental status, is there evidence that the physician conducted an evaluation of the relief and side effects of medication (e.g., over-sedation)?
				• If receiving PRN and routinely, is there consideration for the timing of administration of the PRN?
				• Can staff describe signs/symptoms of over-sedation?
				• Is there evidence of a system for ensuring "hand off" communication includes the resident's pain status and time of last dose?
				• Do the resident, family, and direct caregivers know signs and symptoms of over-sedation and steps to take if noted (e.g., alert the nurse)?
				• Is there evidence the facility implements non-pharmacological pain management approaches?
				• Is there a system to ensure extended-release formulations are delivered correctly (e.g., medications not crushed)?

Please refer to the Adverse Drug Event Trigger Tool

Questions and Discussion

Contact Information:
Jennifer Pettis, MS, RN, CNE, WCC
Associate Director, Long-Term Care Program
NICHE | Nurses Improving Care for Healthsystem Elders
NYU Rory Meyers College of Nursing

Direct: 347-407-4368
Main: 212-998-5445
Email: jenpettis@nyu.edu

www.nicheprogram.org

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