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
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
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, as outlined by 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?
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
- 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)

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

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)

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

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)
Please refer to the Adverse Drug Event Trigger Tool

<table>
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<tr>
<th>Adverse Drug Event (ADE)</th>
<th>Risk Factors - These increase the potential for ADEs. Multiple factors increase risk.</th>
<th>Triggers: Signs and Symptoms (S/S) - Any of these may indicate an ADE may have occurred.</th>
<th>Triggers: Clinical Interventions - These actions may indicate an ADE occurred.</th>
<th>Surveyor Probes - These questions are designed to assist in the investigation. A negative answer does not necessarily indicate noncompliance.</th>
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| Change in mental status/delirium related to opioid use | • PRN or routine use of opioid medication  
• Opioid naïvety (someone who has not been taking opioids) | • Falls  
• Hallucinations  
• Delusions  
• Disorientation or confusion related to opioid use | • Administration of Narcan  
• Transfer to hospital  
• Call to physician regarding new onset of delirium symptoms | • 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 cause? |
| History of opioid abuse  
• Opioid tolerance  
• Severe pain  
• Low fluid intake/dehydration  
• Low body weight  
• History of head injury, traumatic brain injury, or seizures | Anxiety  
• Unresponsiveness  
• Decreased | BP  
• Pulse  
• Pulse oximetry  
• Respirations | relief and side effects of medication (e.g., oversedation)?  
• If receiving PRN and routinely, is there consideration for the timing of administration of the PRN?  
• Can staff describe signs/symptoms of oversedation?  
• 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 oversedation 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)? |
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
References


References


