Pain Assessment and Treatment in the Cognitively Impaired Individual

AUDIO CONFERENCE

Date/Time:
Thursday, December 19, 2013, 10:30 a.m. – noon

Presenter:
Lores Vlaminck, RN, BSN, MA, CHPN, president, Lores Consulting

Packet Contents:
• Handout
• Credit Instructions
• CEU Affidavit
• Evaluation/Credit Form
• Post-Test

Dial-In Instructions:
Conference Phone Number: 866-380-9615
Participant Access Code: 896427#
You may dial the toll-free number no sooner than five minutes prior to the program.
Lores J. Vlaminck, RN, BSN, MA, CHPN
Principal, Lores Consulting

Lores Consulting is a leading provider of consulting, training and mentoring for hospice, assisted living, home care and related health care providers.

Lores Consulting provides clients with education, training and mentoring as well as mock surveys, development analysis and agency reviews. Drawing on her 34 years of professional nursing experience, Lores helps clients maximize their service offerings while minimizing costs. Her extensive nursing background includes clinical practice in cardiac and intensive care, outpatient clinic services as well as serving as a home care and hospice administrator/director for 19 years in greater Minnesota.

In addition to being a certified hospice and palliative care nurse, Lores is also a trainer for the End-of-Life-Nursing Education Consortium (ELNEC) and the Education for Physicians on End-of-Life Care (EPEC) curriculum that encompasses palliative and hospice care. She was recently named 2010 Geriatric ELNEC Educator of the Year by ELNEC.

Speaking topics include end-of-life care, grief and loss, compassion fatigue, professional boundaries, pain and symptom management and many health and employee related topics. Lores also offers national consulting and mentoring services -- encompassing education, training and compliance evaluations -- to hospice and home care agencies, assisted living providers and long-term care facilities.

As Principal, Lores sees her company’s mission to coach and encourage care providers to work to the ‘top of their license’ to ensure excellence in their delivery of care.

Currently, Lores serves as a board member of Minnesota Network of Hospice and Palliative Care, speaker for PESI Healthcare and Hospice Associate for the Corridor Group. She is also a member of Aging Services of Minnesota, MOLN, HPNA and Sigma Theta Tau. Lores is a graduate of Bethel University in St Paul, MN and holds a Bachelor of Science in Nursing degree as well as a Masters in Nursing Education.
Pain Assessment and Treatment of the Cognitively Impaired Individual

Presenter

Lores Vlaminck, RN, BSN, MA, CHPN
- Home Care/Hospice Founder and Director
- Consultant for Home Care, Hospice, Palliative Care, Assisted Living
- ELNEC, EPEC, HPNA curriculum instructor
- Grandmother x 7
- Wife of 1
- Lover of Life

Objectives

- Describe the prevalence of pain in the long-term care setting
- Recognize the impact of pain on patients, families and the healthcare system
- Identify common barriers to effective pain management

Objectives

- Explain the recommended principles, guidelines, and standards for the assessment and management of pain.
- Describe the rationale of a behavioral pain assessment for the cognitively impaired
Under-treatment of Pain

- 70-90% of patients with advanced disease experience pain
- 50% hospitalized patient’s experience pain
- 80% of long term care experience pain
  - Only 40-50% are given analgesics
- Pain scores (on a 0-10 scale) greater than or equal to “4” greatly impact on quality of life

Impact of Poorly Controlled Pain

- Physical
- Psychosocial
- Emotional
- Financial
- Spiritual
- Cultural

Interdisciplinary Resources

- Pain affects multiple dimensions
- No one discipline can address all issues
- Strengths and talents of many disciplines
- Address multiple institutional barriers
- On going communication
Cost of Poor Pain Management

- $100 billion per year
- Chronic pain is most expensive health problem
- 40 million physician visits per year for pain
- 25% of all work days lost are due to pain
- Improving pain management costs less than cost of inadequate relief

Pain Co-morbidities

- Depression
- Anxiety disorder
- Diabetes
- Chronic fatigue syndrome

Barriers to Effective Pain Management

- Patient / family
- Healthcare Provider
- Institutional

Types of Pain

- Acute
  - Accompanied by physiological
  - Perceived as reversible
- Chronic
  - Often not a clear cause
  - Usually persist for longer than 3 months
  - Autonomic nervous system adapts - patient does not exhibit objective signs of pain

Pain Co-morbidities

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- Anxiety disorder
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Classification of Pain

Nociceptive Pain

- The normal processing of stimuli that damages normal tissues or has the potential to do so if prolonged
- Usually responsive to non-opioids and/or opioids
- Stimuli from somatic or visceral structures

Types of Nociceptive Pain

Somatic Pain
- Bone, Joints, Muscle, Skin, Connective tissue
- Throbbing, dull
- Well localized

Visceral Pain
- Visceral organs
  - Often referred to distant dermatomal sites
  - Squeezing, cramping, pressure, deep ache
  - Poorly localized

Neuropathic Pain

- Results from actual injury to nerves rather than stimulation of nerve endings
- Burning, shooting, tingling, numbness, radiating, electrical
- Responds to adjuvant analgesics
Neuropathic Pain

Centrally generated pain
- Deafferentation pain
- Sympathetically maintained pain

Peripherally generated pain
- Painful polyneuropathies
- Painful mononeuropathies

Mixed Nociceptive and Neuropathic Pain Syndrome

- Common in life-threatening illnesses
- Thorough assessment is indicated
- Occur concomitantly so patients may require agents from more than one category of analgesics

Pain Assessment Principles

- Accept patient’s complaint of pain
- History of pain
- Assessment for non-verbal patients
- Patient centered goals

Pain Assessment Principles

- Nonverbal signs of pain
- Psychological impact of pain
- Diagnostic workup
- Assess effectiveness and side effects of pain medication
Initial Pain Assessment

Onset/duration
- When did the pain first begin?
- Is it associated with a particular activity
- Other symptoms

Site
- More than 75% persons with cancer have pain in 2 or more sites
- Ask patient, “To point to the pain”
- Assess each site for pain intensity, quality, duration

Initial Pain Assessment

Severity/intensity
- Select pain scale appropriate to patient

Quality
- Ask patient to describe their pain

Exacerbating/relieving factors
- What makes the pain worse or what causes the pain?
- Assess the pain at rest, with movement, and in relation to daily activity
- Ask the caregivers how patient is doing with activities

Initial Pain Assessment

Effects of pain on quality of life
- What does the pain mean to the patient and family?
- Does the pain keep the patient from doing activities he/she enjoys?

Medication history
- Current
- Past
- Side effects

Initial Pain Assessment

Physical
- Examine site(s) of pain, including referral sites

Consider disease process, extent of progression

Cultural considerations
- Cultural generalities and determine individual differences

Other factors
- Age
- Gender
- Environmental
Position Statement

- Pain is a subjective experience, and no objective tests exist to measure it
- "Pain is whatever the experiencing person says it is, existing whenever he/she says it does"  
  - (McCaffery, 1968).

But... what about those that cannot “say”?

Pain Assessment in Nonverbal Older Adults

- Advanced dementia
- Progressive neurological disease
- Post CVA
- Imminently dying
- Developmentally disabled
- Delirium
ASPMN Position Statement/Guideline

- All persons deserve prompt recognition and treatment of pain even when they cannot express their pain verbally
- Establish a pain assessment procedure
- Use Hierarchy of Pain Assessment Techniques
- Assume pain is present
- Use empirical trials
- Re-assess and document

Differences in the Pain Experience of Older Adults with Dementia

- Tolerance to acute pain possibly increases but pain threshold does not appear to change
- Dementia may alter response to acute pain
- Cognitive impairment may decrease the perceived analgesic effectiveness
- Pain can negatively affect cognitive function

Initial Pain Assessment

Pain Assessment in the Non-verbal patient

- Self-report
- Search for potential causes of pain
- Observe patient behaviors
- Surrogate reporting
- Attempt an analgesic trial

Can Older Adults with Cognitive Impairment (CI) Give Reliable Pain Reports?

- Various studies
  - CI residents slightly underreport pain, but their reports are valid
  - 83% of residents with mild to moderate CI could reliably complete at least one pain scale
  - 73% of post-op patients with moderate CI were able to complete a 4-point verbal descriptor scale
Ethical Tenets for Pain Assessment and Treatment

- Beneficence
- Non-maleficence
- Justice

Self-Report

- Attempt self-report
  - Simple ‘yes’ or ‘no’ or other vocalizations or gestures
  - Hand-grasp/eye blink

Search for Potential Causes of Pain

- Pathological
  - Surgery, trauma, osteoarthritis, wound care, rehabilitation, turning, repositioning, distended bladder, constipation, lab draw,UIT, URI, other infection

Observe Patient Behaviors

- Sensory
- Behavioral
  - behavioral pain score should not be considered to be equivalent to a self-report of pain intensity
Behavioral/Observational Cues

**Obvious:**
- Grimacing or wincing
- Bracing
- Guarding
- Rubbing

**Less Obvious:**
- Changes in activity level
- Sleeplessness, restlessness
- Resistance to movement
- Withdrawal/apathy
- Increased agitation, anger, etc.
- Decreased appetite
- Vocalizations

Proxy Reporting of Pain and Behavior/Activity Changes

- Family Members, Parents, Unlicensed Caregivers, Professional Caregivers)

Attempt an Analgesic Trial

- An empiric analgesic trial should be initiated if there are pathologic conditions or procedures likely to cause pain or if pain behaviors continue after attention to basic needs and comfort measures.

Analgesic/Empirical Trial in Nonverbal Older Adults for Pain Relief

- Try pain medicine
- Behaviors suggest it could be pain
- Behaviors decrease
- It's probably pain!
American Society for Pain Management (ASPM) for pain assessment in the nonverbal patient reminds us that “no single objective assessment strategy...is sufficient by itself.”


Behavioral Pain Assessment Tools
- CNPI-
- Checklist of Nonverbal Pain Indicators
- CPAT-
- NOPPAIN-
- Nursing Assistant–Administered Instrument to Assess Pain in Demented Individuals
- Mahoney Pain Scale-

Behavioral Pain Assessment Tools
- PACSLAC-
  - Pain Assessment Scale for Seniors with Severe Dementia
- PAINDAD-
  - Pain Assessment in Advanced Dementia Scale-
- PAINE-
  - Pain Assessment in Non-communicative Elderly Persons

WHO Ladder Recommendations
- Portrays progression in the doses and types of analgesic drugs for effective pain relief
- Changes as patients condition and characteristics of pain change
- Orally whenever possible
- “By the clock” dosing
- Based on assessment of the individual’s pain experience
WHO Ladder
Step 1 (Mild pain)
Mild Pain
• 1-3 on a scale of 0-10
• Non-opioids
• Adjuvants
  • As analgesics
  • To reduce side effects

WHO Ladder
Step 2 (Moderate pain)
Moderate Pain
• 4-6 on a scale of 0-10
• Opioids in low doses
• Non-opioids and adjuvants may be continued

WHO Ladder
Step 3 (Severe pain)
Severe Pain
• 7-10 on a scale of 0-10
• Add higher doses of opioids
• Continue non-opioids and adjuvants

Summary
• Describe the prevalence of pain in the long-term care setting
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Summary

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CREDIT INSTRUCTIONS

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Credit Available: 1.5 hours of Licensed Nursing Home Administrator (NAB), Adult Care Facility (ACF) or Assisted Living (AL) credit for up to 4 individuals from the same facility (no affiliates).

Instructions for Obtaining Credit:
Please complete and fax the following forms to 518.867.8386 or 518.867.8389 no later than January 2, 2014:
- CEU Affidavit
- Evaluation/Credit Form
- Post-Test

Print the credit forms for each individual seeking credit. On each form, indicate the name of the person that your organization’s registration is under.

Please note: Credit certificates will be issued approximately one month after the program if payment has been received in full.

Credit Details: The FLTC is a certified sponsor of professional continuing education with the National Association of Boards of Examiners of Long Term Care Administrators (NAB). NAB has approved this program for 1.5 hours of continuing education credit. State licensure boards, however, have final authority on the acceptance of individual courses. A certificate of completion will be sent to adult care facility (ACF) and assisted living administrators with a maximum of 1.5 hours awarded.

If you have any questions, please contact Linda Smith at 518.867.8385, ext. 154 or lsmith@leadingagency.org
CEU Affidavit

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Organization: ________________________________________________________________________

Name of Registrant: ____________________________________________________________________

This form attests that _________________________________________________________________,
(Full name of person seeking credit)

____________________________________________, was in attendance for the full 1.5 hours of the
(Title)

audio conference, Pain Assessment and Treatment in the Cognitively Impaired Individual.

Witness: (Print) _______________________________________________________________________
(Staff in attendance, other than the person seeking credit)

(Signature) ___________________________  Date: _______________
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EVALUATION
1. How many other staff from your organization were listening to the audio conference with you? _______________

2. Please check the box that best describes your rating: Excellent Good Fair Poor
   a. Overall rating
   b. Presenter’s knowledge of material/topic
   c. Learning objectives & content material
   d. Usefulness of the knowledge/skill required
   e. Appropriateness of topic content

3. Was participating in this seminar a wise business decision? Yes No
   If not, why? _______________________________________________________________

4. Is LeadingAge New York/FLTC your first choice for educational opportunities? Yes No

5. What new developments in the field do you believe will have an important future impact?
   ______________________________________________________________________
   _________________________________________________________________

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This program has been reviewed and approved by NAB/NCERS. NCERS strives to approve only quality programs whose content can reasonably contribute to the professional development of long-term care administrators. If you have any confidential comments concerning this program, which you would like to make to NCERS administrators, please direct them to cecomments@nabweb.org.
Post-Test

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Name of Registrant: ________________________________________________________________

Name of Person Seeking Credit: ____________________________________________________

PLEASE CIRCLE THE CORRECT ANSWER:

1. Pain scores greater than or equal to “4” greatly impact on the quality of life.
   a. True
   b. False

2. Chronic pain is the second to most expensive health problem.
   a. True
   b. False

3. Neuropathic pain results from actual injury to nerves rather than stimulation of nerve endings.
   a. True
   b. False

4. The psychological impact of pain is not considered to be a pain assessment principle.
   a. True
   b. False

5. The initial pain assessment includes assessing each site for pain intensity, quality and duration.
   a. True
   b. False

6. Perceived analgesic effectiveness may be decreased by cognitive impairment.
   a. True
   b. False

7. An empiric analgesic trial should not be initiated if there are pathologic conditions or procedures likely to cause pain.
   a. True
   b. False

8. Approximately 80 percent of long term care residents experience pain but only 40-50 percent are given analgesics.
   a. True
   b. False