Nonpharmacologic Approaches to Managing Pain in Older Adults with Cognitive Impairment

April 5, 2016

No Reported Conflict of Interest

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Objectives:

1. **Discuss approaches to assessing pain in older adults with cognitive impairment.**
2. **List evidence-based tools for assessing pain in older adults with cognitive impairment.**
3. **Understand ways to utilize certified nursing assistant skills to identify & approach pain in residents with cognitive impairment.**
4. **Describe the survey process utilized to determine compliance with federal regulations & management of pain.**

What is Pain?

- **An unpleasant sensory & emotional experience associated with actual or potential tissue damage, or described in terms of such damage** *(International Association for the Study of Pain, 1979)*
- **The clinician must accept the patient's report of pain** *(American Association of Pain, 2003)*
- **A subjective experience & no objective tests exist to measure it** *(American Pain Society, 2009)*
- **Whatever the experiencing person says it is, existing whenever the person says it does** *(McCaffery, 1968)*

What is Wrong with these Definitions?

- **Older adults tend to under report pain**
- **Individuals with cognitive impairment (CI) may experience pain differently**
- **CI impairs ability to describe symptoms**
- **When CI becomes dementia, the ability to communicate & remember pain becomes increasingly difficult**
- **Pain is undertreated in dementia** *(Sarbacker, 2014)*
- **Presentation of pain may be non-specific**
- **Consider pain the 1st vital sign**
- **There are no universal tests for pain**

- **All pain is a very individualized subjective experience**
- **Chronic pain is one of the most common conditions in older adults & is associated with substantial disability & costs** *(Reid et al., 2016)*
- **Older adults living with dementia are at risk for multiple sources & types of pain** *(Horgas, 2012)*
- **Untreated pain in cognitively impaired older adults can delay healing, disturb sleep & activity patterns, reduce function, reduce quality of life (QOL) & prolong hospitalization**

Older adults with chronic pain are receptive to nonpharmacologic approaches (NPAs)

Management of chronic pain in older adults is complicated by age-related physiologic changes, competing comorbidities that limit treatment choices, numerous resident/family/provider barriers & limited evidence base to guide treatment decisions

Assessment Guidelines:

- **Attempts should be made to obtain self-report of pain from all residents** *(Herr et al., 2011)*
  - **Yes/no**
  - **Vocalizations**
  - **Gestures**

- **Search for potential causes of pain**
  - **Pathologic conditions** *(trauma, OA, wounds, history of persistent pain, procedures)*
- **Observe resident behaviors**

- **Proxy Reporting**
  - **Family members ***
    - **Compare customary behavior to current**
  - **Caregiver input ****
    - **Front-line staff (CNAs)**
    - **Other facility staff**

- **Attempt an analgesic trial**
  - **If no conditions/causes are identified, a low dose of an analgesic trial should be given**
    - **Based on resident's pathology, analgesia history & things resident enjoys**

However …

- **Must use NPAs at the same time**
- **Observation**
  - **What works & does not work?**
  - **Trial & error**
- **Documentation – <u>EXTREMELY</u> important!**
  - **Effectiveness of medication**
  - **Effectiveness of NPAs**
  - **How do you know?**

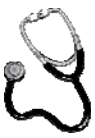
Common Pain Behaviors:

- **Facial expressions** *(frowning, grimacing, distorted expression, rapid blinking)*
- **Verbalizations/vocalizations** *(sighing, moaning, grunting, calling out, asking for help, verbal abuse)*
- **Body movements** *(rigid posture, tense, guarding, fidgeting, increased pacing/rocking, gait or mobility changes [inactivity, restlessness, wandering])*
- **Changes in interpersonal interactions** *(aggressive, combative, resisting care, disruptive, withdrawn, socially inappropriate)*

- **Changes in activity patterns or routine** *(appetite change, refusing food, throwing food, sleep pattern changes, sudden cessation of common routines)*
- **Mental status change** *(crying, increased confusion, irritability, distress)*

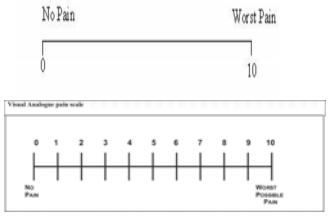
- **Physiological changes:**
  - **Increased heart rate**
  - **Increased blood pressure**
  - **Increased respiratory (breathing) rate**
  - **Diaphoresis**
  - **Pupil dilatation**

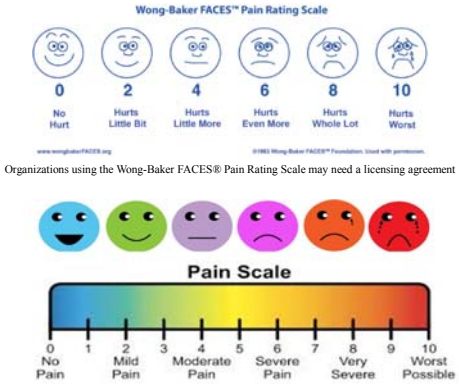
TOOLS



Mild to Moderate CI or Dementia:

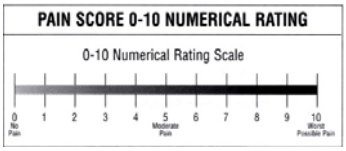
- **Simple**
- **Pictorial**
- **Reliable & valid**
- **Evidence-based**
- **Types:**
  - **Visual analog scales** (VAS)
  - **Faces Pain Scale**
  - **Numeric rating scale** (NRS)

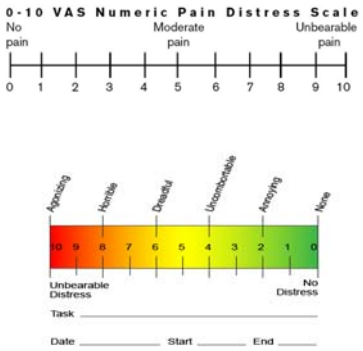




Organizations using the Wong-Baker FACES® Pain Rating Scale may need a licensing agreement

0-10 Numeric Pain Rating Scale





Advanced or Severe Dementia:

- **More difficult**
- **Attempt self-report 1st!**
- **Observation scales**
  - **Developed to provide a clinically relevant & easy to use observational pain assessment tool for individuals with advanced dementia**
- **Example**
  - **Pain Assessment in Advanced Dementia** (PAINAD)

PAINAD:

- **Observe the resident x 3 - 5 minutes before scoring**
- **5 variables: breathing, vocalization, facial expression, body language, consolability**
- **Different circumstances:**
  - **Resting**
  - **Engaged in a pleasurable activity**
  - **During movement** *(personal care, transfer, ambulation, etc.)*
  - **When alone & with others**
  - **After administering pain medication**

Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

Behavior	0	1	2	Score
Breathing Independent of vocalization	• Normal	• Occasional labored breathing • Short period of hyperventilation	• Noisy labored breathing • Long period of hyperventilation • Cheyne-Stokes respirations	
Negative vocalization	• None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	• Smiling or inexpressive	• Sad • Frightened • Frown	• Facial grimacing	
Body language	• Relaxed	• Tense • Distressed 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	
			TOTAL SCORE	

(Warden et al., 2003)

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident: .....

Name and designation of person completing the scale: .....

Date: .....**Time:** .....

Latest pain relief given was.....**at** .....**hrs.**

Q1. Vocalisation
eg. whimpering, groaning, crying — Q1
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression
eg: looking tense, frowning grimacing, looking frightened — Q2
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language
eg: fidgeting, rocking, guarding part of body, withdrawn — Q3
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural Change
eg: increased confusion, refusing to eat, alteration in usual patterns — Q4
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change
eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor — Q5
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes
eg: skin tears, pressure areas, arthritis, contractures, previous injuries. — Q6
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 – 6 and record here ⇒ Total Pain Score

Now tick the box that matches the Total Pain Score ⇒

0 – 2	3 – 7	8 – 13	14+
No pain	Mild	Moderate	Severe

Finally, tick the box which matches the type of pain ⇒

Chronic	Acute	Acute on Chronic

Dementia Care Australia Pty Ltd
Website: www.dementiacareaustralia.com

Abbey, J. De Bellis, A. Piller, N. Esterman, A. Giles, L. Parker, D and Lowcay, B. (2004) The Abbey Pain Scale: A 1-minute numerical indicator for people with dementia. (This document may be reproduced with this acknowledgment retained)

The Surveyor's Perspective

Risk of Medication Use for Pain Tx in Elderly

- **Decrease in muscle mass**
- **Increased fat mass**
- **Decreased renal clearance**
- **Reduction of hepatic phase I reactions**
  (oxidation, hydrolysis, reduction)
- **Decreased serum albumin**
- **Increased sensitivity to centrally acting drugs**

Standard Survey Process

- **Pre survey sample selection (facility quality indicators)**
- **Survey sample phase 1 & 2**
  - **Comprehensive/focused resident review + case-mix stratified** *(statutorily required)*
- **Resident review quality of life (5C)**
  - **Meals, treatments, medication, activity, special rehab, physician visits**

- **Resident QOL assessment**
  - **Interviews**
  - **Observations of residents**
- **Medication pass & Pharmacy services (5E)**

CMS Investigative Protocol for Pain Management (F309)

- **Who states he/she has pain**
- **Who displays possible indicators of pain not readily attributed to another cause**
- **Who has a disease or condition or receives treatments that cause or can cause pain**
- **Whose assessment indicates that he/she experiences pain**

- **Who receives or has orders for treatment of pain**
- **Who has elected a hospice benefit for pain management**

Procedures F309

- **Care plan review**
- **Observations**
- **Resident/representative interviews**
- **Nurse aide interviews**
- **Record review**
  - **Pain assessments**
  - **Pertinent nonpharmacological interventions**

- **Identification of clinically significant medication-related adverse consequences**
  - **Falling; constipation; anorexia; drowsiness (F329)**

- **Care plan**
  - **Revisions, monitor effectiveness, coordinate with hospice & wound care specialist**

Criteria for Compliance with F309 for a Resident with Pain or the Potential for Pain

- **The facility is in compliance with F309 Quality of Care as it relates to the recognition & management of pain, IF each resident & the facility has provided the necessary care & services to attain or maintain the highest practical physical, mental & psychosocial well-being, in accordance with the comprehensive assessment & plan of care**
- **Review: right to refuse treatment (F155)**

State of Michigan Clinical Process Guidelines (Entrance Conference Checklist)
http://www.michigan.gov/lara/0,4601,7-154-35299_28142_27655_31223-174899--,00.html

You have additional information from this site at the end of your handout!

Role of the Certified Nursing Assistant

Screen & Report

- **Shift-work**
  - **CNA to CNA reports**
    - **Minimal on nights**
    - **New medications or change in dose**
    - **Incidents that occur during shift that can impact behaviors related to pain**
- **Continuity of care**
- **Relationships**
  - **Knowing the resident**
  - **Knowing the family**

- **Assessing for pain**
  - **Know the residents "usual" self**
  - **Looking for signs/symptoms of change**
    - **Mood**
    - **Not wanting to attend normal activities**
    - **Body language**
  - **Investigate for clues**
    - **Why is there a change?**
    - **What is different?**
      - **New meds, unreported fall/injury, specific visitors**

- Nonpharmacologic approaches
  - Need to take a holistic approach
  - Strategies:
    - Walking
    - Positioning
    - Repositioning
    - Redirecting
    - Massage

→ Case Studies

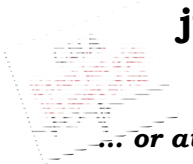
It Takes a Village

to

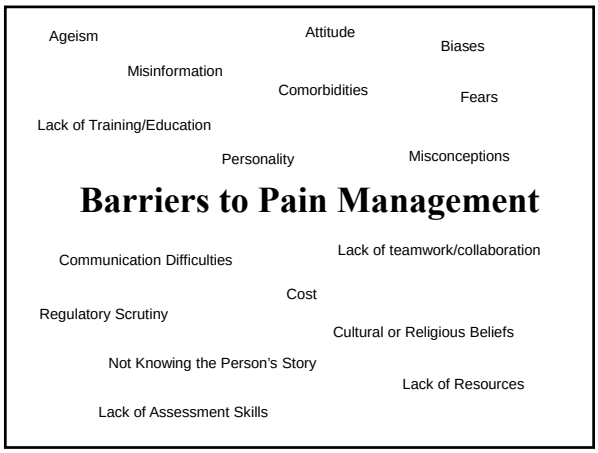
Sustain a Resident!

24/7 Care!

Being a CNA
is
MORE THAN
just a job!



… or at least it should be!



- ***Myths:***
  - **Pain is inevitable & normal in older adults**
  - **Older people experience less pain than their younger counterparts**
  - **If a person doesn't say they are in pain, they must not be having pain**
  - **If a person does not look like they are in pain, they probably are not having pain**
  - **Residents with dementia are unable to report their pain**
  - **Doctors & nurses are the experts about pain**

- **Many older adults expect pain with aging**
- **Many long-term care residents fail to report pain because they do not want to be a nuisance to staff or they get tired of asking for pain management & are not listened to** *(Herr & Garand, 2001)*
- **Older adults sometimes have fear of the consequences of acknowledging their pain**
- **Behaviors & vocalizations are often attributed to cognition & pain is not considered** *(Chandler & Bruneau, 2014)*
- **Psychotropic drugs mask pain**

- **Observation of pain (PAINAD):**
  - **Not researched for mild-moderate dementia**
  - **Some of the behaviors (breathing) are difficult to accurately assess**
  - **Only 5 items limits the applicability by restricting the range of behavioral pain indicators that may be observed**
  - **No clear guidelines on how to treat the pain based on the score**
- **Belief that strong analgesics & opioids should be avoided in older adults**

Nonpharm Approaches (NPAs)

*** = empirically supported; evidence based**

√ = MDS 3.0 RAI Manual – Section J

Advantages:

- **Addresses the psycho-social-spiritual-cultural-environmental potential reason for the pain**
- **Holistic & resident (person) centered**
- **Avoids use of medications that can decrease QOL**
- **Preserves communication & interaction**
- **Creates memorable moments**
- **Improves/maintains QOL for all involved**

- * √ **Activities** *(pleasurable, hobbies)*
- * √ **Assistive devices**
  - **Eye glasses, hearing aids, canes, WC; shoes, clothing**
- * √ **Bathing alternatives**

  - **Bathing without a Battle** *(Barrick et al., 2002)*
- * **Behavior plans** *(individualized care plans)*
- * **Communication**
  - **Slow, repetitive, simple explanations**
- * **Consistent daily routines**

- * √ **Distraction / diversion**
  - **Person-centered**
  - **Everyone is a unique individual**

- * √ **Education** ***(staff, caregivers, families & providers)***
  - **Lack of resident intentionality, dementia & delirium sx, communication skills, physical approach during ADLs & transfers, focus on emotion vs. content (validation), directions 1 step @ a time, use of distraction vs. logic, predictable schedule, use familiar staff**

- * √ **Environment modification**
  - **Lighting, sound, temperature, smells**
  - **Home-like**
  - **Decrease stimulation**
  - **Comfortable seating** *(arms, back support)*
  - **Mattress** *(pressure redistributing)*
  - **Bed height**
  - **Positioning/repositioning** *(neutral body alignment)*
  - **Smooth & tight linens**
  - **De-clutter**
  - **Placement of furniture**

- **Increase signage & access to toilets**
- **Improve time orientation**
  - **Clocks, calendars, staff names**
- **Small scale group living**

- **Separate individuals with dementia from other residents**
- **No overhead paging system**
- **Minimize testing of fire alarms, weather alerts unless 1st talking with residents** (PTSD)

- *** √ Exercise** *(physical activity)*
  - **Aerobic, low impact, water** *(hydrotherapy)*
  - **Stretching & strengthening are effective exercises for improving pain & function**
  - **Tai chi, Pilates, yoga, chair**
- **Humor & laughter**

- *** Listening**
  - **Active, reflective, intentional**
- **Logs** *(tracking: B&B, behaviors, pain, sleep)*
- *** √ Massage** *(body, feet, hands, legs)*
- **Mindfulness meditation**

- *** √ Music or music therapy** *(MT)*

- *** Observation**
- *** √ Packs:**
  - **Cold** *(numb)***; heat** *(sore muscles; old injuries)*
- *** Pet visitation; animal assisted therapy (AAT)**
- **Photography**
- *** Presence –being with; empathic**

- *** √ Relaxation techniques**
- *** √ Reminiscence; life review**
- **Silence (therapeutic; compassionate intention)**

- * Sleep hygiene
- * Social interaction
- Spirituality / religion / faith
- * √ Transcutaneous Electrical Nerve Stimulation (TENS)
- Therapeutic use of self
  - *YOU are an intervention!*
- Touch
  - Therapeutic (TT); healing; M-technique (stroking in cycles of 3)
  - Rocking, holding, cuddle, hug, handshake

- Visits, telephone calls, Skype, Zoom
  - Friends, family, health care professionals, staff, community organizations
- Lifestyle changes:
  - Adequate sleep
  - Balanced diet
  - Drinking plenty of water
  - Limiting caffeine
  - Smoking cessation

PEARLS

Pain is always subjective!

Pain can exist even when no physical cause can be found!

Assume that older adults with CI or dementia have pain if they have conditions typically associated with pain!

Residents are unique individuals with their own needs, wants & desires! Options & choices are paramount!

A uniform pain threshold does not exist!

A pain assessment should address physical, psychological & spiritual aspects of pain

NPAs are effective in pain management!

Know the person's story!

Be proactive, preventative, positive & hopeful!

References & Resources

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State Operations Manual Appendix P-Survey Protocol for Long Term Care Facilities – Part I

State of Michigan Clinical Process Guidelines for Pain Management (rev. 2/13/2014)

Advancing Excellence in America's Nursing Homes. https://www.nhqualitycampaign.org/goals.aspx
- Clinical Outcome Goals: Pain
- Create Improvement: Managing Pain
  - Guide to Evidence-Based NonPharmacologic Interventions for Pain

https://www.nhqualitycampaign.org/files/Guide_to_Evidence based_NonPharmacologic_Interventions_for_Pain.pdf

Clinical Process Guideline: Pain Management

Nonspecific Signs & Symptoms that suggest the Presence of Pain (Table 3)

- **Frowning, grimacing, fearful facial expressions, grinding teeth**
- **Bracing, rubbing**
- **Fidgeting, increasing or recurring restlessness**
- **Striking out, increasing or recurring agitation**
- **Eating or sleeping poorly**
- **Sighing, groaning, crying, breathing heavily**
- **Decreasing activity levels**
- **Resisting certain movements during care**
- **Change in gait or behavior**
- **Loss of function**

Clinical Process Guideline: Pain Management

Possible Indicators of Chronic Pain in MDS-Version 3.0 (Table 4)

- **Sleep cycle** (E1)
- **Sad, apathetic, anxious appearance** (E1)
- **Change in mood** (E3)
- **Resisting care** (E4)
- **Change in behavior** (E5)
- **Loss of sense of initiative or involvement** (F1)
- **Functional limitation in range of motion** (G4)
- **Change in ADL function** (G9)

- **Any disease associated with chronic pain (e.g., diabetes, arteriosclerotic heart disease, peripheral vascular disease, arthritis, hip fracture, osteoporosis, pathological bone fracture, stroke, multiple sclerosis, depression)** (11)
- **Pain** (J2)
- **Pain site** (J3)
- **Mouth pain** (K1)
- **Weight loss** (K3)
- **Oral status** (L1)

- **Skin lesions** (M1)
- **Other skin problems** (M4)
- **Foot problems** (M6)
- **Range of motion restorative care** (P3)

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Clinical Process Guideline: Pain Management

Complimentary (Nonpharmacologic) Therapies for Which Evidence of Effectiveness Exists
(Table 18)

- **Education**
- **Cognitive/behavioral therapy**
- **Exercise**

Other Complementary Therapies:
Although no scientific evidence supports the effectiveness of these therapies in elderly patients in the LTC setting, they may be beneficial to some individuals

AMDA Clinical Practice Guidelines, 1999

- **Physical:**
  - **Physical & occupational therapy**
  - **Positioning** *(braces, splints, wedges)*
  - **Cutaneous stimulation** *(superficial heat or cold, massage therapy, pressure, vibration)*
  - **Neurostimulation** *(acupuncture, transcutaneous electrical nerve stimulation)*
  - **Chiropractic**

- **Nonphysical:**
  - **Psychological counseling**
  - **Spiritual counseling**
  - **Peer support groups**
  - **Alternative medicine** *(herbal therapy, naturopathic & homeopathic remedies)*
  - **Aromatherapy**
  - **Music, art, drama therapy**
  - **Biofeedback**
  - **Meditation, other relaxation techniques**
  - **Hypnosis**