Long-Term Care Survey Alert

PAIN MANAGEMENT: Dont Mistake Pain For Dementia-Related Behavioral Symptoms

This assessment approach can prevent unnecessary antipsychotic drug use.

Sometimes you almost need a sixth sense to know if a cognitively impaired resident is acting out because hes in pain. Yet the right pain assessment protocol and tools can help you tell the difference between pain and dementia-related neuropsychiatric disturbances. And that protects residents who are in pain from suffering unnecessarily and it protects your facility from F tags for unnecessary drugs (F329) or inappropriate use of antip-spychotic drugs (F330, F331) and poor pain management (F309).

The biggest red flag that a patient with dementia is having pain is a change in behavior, especially aggression or resistance to care, says nurse practitioner **Karen Feldt**, an associate professor of nursing at the **University of Minnesota**. "So as a first step in improving pain management, staff has to avoid using behavioral changes as a trigger to ask the physician to order psychoactive drugs or increase [the residents] dosage," she emphasizes.

Not only do antipsychotic medications fail to relieve pain, they distort the residents perception and ability to respond, according to Feldt. "And this can create a vicious cycle where the residents pain-related behavior escalates, so the physician increases the antipsychotic medication," she cautions. Then the resident develops restlessness due to the medication, which the physician may treat with even more medications.

In other words, the approach doesnt help the resident, it drains your fixed PPS rate and its a perfect setup for an F329 tag, if surveyors figure out whats driving the trail of meds.

Be a Pain Detective

You have to be a good sleuth to differentiate between behavioral symptoms due to dementia and those caused by pain. Start by looking for reasons why a resident with dementia might be in pain, suggests **Cheryl Field**, director of clinical and reimbursement services for **LTCQ Inc**. in Lexington, MA. "For example, does he have a diagnosis of osteoarthritis, which is known to be painful?"

Say a resident with a history of prostate cancer suddenly starts acting out. "Perhaps he has some metastases that are causing pain and require a work-up to detect," Field says. "Urinary tract infection (UTI) can be very painful: Does the person have increased frequency or more urinary incontinence episodes of late?"

Real world problems, real world solutions: One resident would take a swing at anyone who approached her from the left side and touched her on the left shoulder, reports **Jan Stewart**, a nursing consultant with **QUnique Corporation** in Carroll Valley, PA. Turns out the woman had a visual defect on that side. And unbeknownst to staff, she had fallen and partially dislocated her left shoulder, which an X-ray later confirmed. "This is typically the type of resident who would have been considered for a psychotropic med, when she truly needed medical intervention and pain management," notes Stewart.

Use Specific Assessment Formats

Experts also suggest using specific assessment formats for cognitively impaired residents. But gear the approach to the residents level of dementia. "For example, some residents with moderate to even more severe cognitive impairment can still indicate that they hurt when they move," Feldt says.

"Since reading skills are often the last to go in dementia, you might try a large print verbal descriptor pain scale to see if

the resident can communicate pain that way," she adds. **Tip**: When using such a scale, try exchanging the word "pain" for terms like "aching" or "soreness." Feldt suggests.

To assess residents who can no longer communicate with words or confirm they have pain, nurses can use a checklist of nonverbal pain indicators (see "Checklist of Nonverbal Pain Indicators").

If you suspect a resident with dementia is in pain, ask the physician to put him on a three-to-five day course of scheduled extra-strength acetaminophen, which might help arthritic pain. Feldt reports success in taking dementia patients off their psychoactive medications and putting them on Tylenol or anti-inflammatory drugs around the clock. "Their behaviors, cognition and quality of life all improve," she says.

Keep an Open Mind

Finally, dont let preconceived notions of a particular resident get in the way of effective pain management. Feldt recalls one resident with a long history of dementia-related aggressive behaviors. The resident had a fractured hip repaired in the hospital and returned to the SNF on the antipsychotic drug, Prolixin. The residents aggressive behavior escalated in the SNF and the physician bumped up his Prolixin three times. Yet when Feldt showed the resident a pain descriptor scale, he pointed right at the extreme pain.

"The clinical staff was horrified as the light bulbs went off that his behavior was pain related," Feldt adds. "But everyone had had a preconceived image of him as being naturally aggressive due to his dementia, and that led them down the wrong treatment path."