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MDS Alert

IN THE SPOTLIGHT: Rein in Pain Rates and Other Negative Outcomes

Don't reinvent the wheel: Lessons learned help you move forward quickly.

Saint Elizabeth Home's effort to revamp its pain management program required careful self-examination and a ramp-up to get everyone on the same page.

But the initiative paid off in spades for residents who are now more pain free, and for the facility's quality profile. The QI team, in fact, not only saw a significant improvement in the facility's pain quality measures, but also found that a number of other outcomes fell in line, reported **Janelle Hackett, RN**, a member of the project's QI team at the facility in East Greenwich, R.I.,in a presentation at the fall 2008 American Association of Homes & Services for the Aging annual conference. Residents were participating more in activities, had improved physical functioning, and less depression and weight loss, she said.

Another perk: Overall resident and family complaints about other things decreased. As a potential explanation for that outcome,Hackett noted that "when we are in pain, everything seems to be wrong and we like to complain about it."

Consider This Blueprint for Quality Improvement

Hackett and other nurses from the facility shared pointers for how to proceed and succeed in rolling out a new pain management program.

1. Get the inside scoop on how you're really doing before you try to improve. To lay the groundwork for its pain QI project, St. Elizabeth's took notes from its customers -- literally.

In interviewing residents, the team found that some of them felt a lack of concern about their pain from physicians, nurses, and even their own families, relayed Hackett. In some cases, the residents felt that staff ignored or even dismissed their complaints of pain. Others noted that no one asked them how they felt so they had to always ask for a pain med. Some waited until the pain became intolerable.

Some family members said they didn't want their resident to receive a pain medication that caused any type of confusion. Others wanted their family member to be pain free, which might not be a completely realistic goal.

The QI team found out that some staff felt that certain residents didn't look like they were in pain even though they were complaining about discomfort.

2. Cast a wider pain assessment net. The QI team decided to formally assess residents' pain at admission, readmission, and anytime they had a change in condition or pain medication, including a different dose of the same med. The team also increased the assessment timeframe from three days to seven in all cases. That way the staff could capture residents who might not complain about pain until the third or fourth day after admission -- or when the clinician tapered their pain medication after admission, reported **Lisa Lavigne, RN**, in the AAHSA presentation. The team also decided to require a pain assessment any time the resident had any type of surgical procedure, including a lumpectomy, as an example. "We found that many times patients come from the hospital after surgery on Tylenol," Hackett tells **Eli.**

To help staff assess cognitively impaired, non-verbal residents, the QI team came up with a list of behaviors associated with pain, including facial grimacing, guarding, not walking, agitation, and battling care. If a resident displayed those behaviors, the staff would ask the physician to put him on a pain medication. Then they'd restart the clock on the seven-day assessment to see if the medication appeared to be helping. Often they saw the resident had less agitation, guarding, and fighting,etc., so it worked, said Lavigne.

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3. Develop a standardized pain management protocol that everyone follows. The interdisciplinary QI team worked with its consultant pharmacist and medical director to identify commonly ordered pain medications, dividing them into nonpharmacy meds, topical, oral, transdermal,narcotics, neuroleptics and migraine meds, relayed Lavigne. The team then divided those medications into those used to treat mild, moderate and severe pain. They also identified a category for treating allergicreactions to the medication (see the next page).

The physician signs off on the resident's medication protocol, which lists the preferred medications for the patient at different levels of pain,says **Andrea Smith, RN**, director of nursing for the facility. The doctor can, of course, tailor the edications and dosages. The pain medication protocol also addresses potential side effects, including the potential for narcotics to cause nausea or sedation for a 24 to 48 hour period. That way,caregivers remember to monitor the resident during that time to see if he needs an antiemetic, for example,and also educate residents and families about what to expect.

4. Customize education to various groups, jazz it up. Once the team had developed the pain program,then education became the name of the game. The educational effort included a kick-off blitz with posters, banners, buttons, crossword puzzles and trivia contests, etc.,Smith told AAHSA conferees. In addition to traditional classroom inservices, the team provided miniinservices to address everyone's educational levels and needs across shifts. Someone in dietary didn't need all the same information as nursing staff, Smith noted, but we wanted them to know what to look for to detect pain.

Key educational points: The educational effort underscored that pain can differ from person to person or even hour to hour or minute to minute, said Smith.

Staffing education is important, emphasizes Hackett. "We [as caregivers] believed many times that we could tell by the way someone was acting that they were in pain, and that's not always true," she says.

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