

MDS Alert

Pain Management: Cover All The Bases When Residents Refuse Optimal Pain Control

This 6-point plan assures you've done everything you can do.

Residents in pain who say no to the opiates that could bring them complete relief pose more than a tough clinical dilemma - they can also drive up your facility's pain quality measure scores. And that leaves you in the hot seat for explaining to surveyors and consumers how the facility does everything possible to help residents choose the level of pain control that works best for them.

To make sure you've covered all the bases in care planning for residents who refuse optimal pain management, follow this six-point plan.

1. Assess and document the resident's desired level of pain control and functional goals. For chronic pain sufferers, that might include being able to perform activities of daily living and get restful sleep, according to **Margo McCaffrey**, a nurse consultant in Los Angeles who helped develop pain guidelines for the Agency for Healthcare Policy & Research and the World Health Organization.

The prescribing clinician can tailor medications to meet the resident's functional goals. "There are things you can do with the timing of medications, for example, to target intervention at night for sleep," says **Karen Clay**, with **Kare 'N Consulting** in Brimfield, MA. One such measure is to "use a medication with a longer half-life so the person gets the tail end of the relief during waking hours," when he wants to be more alert to participate in activities or visit with family, she suggests

2. Determine if the person is choosing to hurt in order to be alert or avoid other opiate-related effects. Is the person in pain because he can't tolerate or fears the side effects of opiate medications? "It's important to encourage patients to try a fair trial of such medications to see if the mental side effects subside, which they often do within several days on a stable dose," says **Rhonda Nichols**, a clinical specialist and pain management consultant in San Francisco. Of course, you have to work with the person to find the right dose and medication. The problem is that some people, especially elders, are so distressed by the initial period of confusion that they are not willing to see if that side effect wears off in several days. Or a resident's family may object to the drug's effect on the resident's sensorium. So the resident (or family) may need a lot of support to get through that period.

If a resident starts an opiate, such as morphine, and finds the drug-related confusion persists more than a week or so, switch to another choice, such as Oxycodone or Dilaudid, suggests McCaffrey.

Medication-related nausea also can be a stumbling block for residents seeking pain relief. Yet Phenergan-opioid combinations tend to increase the resident's sedation, Nichols cautions. As an alternative, she suggests facilities try the newer antiemetic, Zofran. "While Zofran is more expensive, you might be able to ward off nausea by treating the resident prophylactically with the medication for two to three days when he starts an opioid drug," she says. "Then try administering the opiate drug without the Zofran to see if the resident develops nausea," which is sometimes a temporary side effect.

Assessment Tip: Try to figure out if the resident's nausea and vomiting are actually due to constipation. "If the patient vomits 30 minutes after getting the opiate medication, that's more likely to be due to the drug's onset of action," Nichols says.

In any case, residents taking opiate medications require a good bowel management program to prevent constipation and potential fecal impaction (a sentinel event on the QIs). "There are some good recipes for fruit paste and dietary regimens to address this issue," Nichols says, "but some patients will also need a combination of a mild stimulant to improve intestinal motility and sorbitol or one of the senna products."

You may also have to dispel the resident's or his family's fear of addiction. "Studies repeatedly show such fears are unwarranted," says geriatrician **David Gifford**, principal clinical coordinator for **Rhode Island Quality Partners**, the quality improvement organization in that state. "The much greater risk is that the healthcare staff's or the patient's own fear of addiction will cause him to suffer needlessly," he emphasizes.

3. Adequately assess the etiology of the resident's pain, especially new or different pain. Many medical problems first manifest as pain, including cancer. And pain can sometimes be a sign of a serious acute condition even in someone with a chronic painful condition, Gifford notes. "Examples include abdominal pain, new onset of headaches, chest pain, or bone pain - if the latter is new, different or more intense." **Clinical Tip:** "A normal X-ray does not exclude a fracture," said **Malcolm Fraser**, a physician and president of **Bay Geriatrics** in St. Petersburg, FL, speaking at the September meeting of the **American Association of Nurse Assessment Coordinators**. "So if the resident with a normal X-ray continues to complain of bone pain or has reduced function, consider obtaining an MRI or CT scan," he suggested.

4. Try milder analgesics or other types of non-opiate medication for certain types of pain. Elderly people may have different types of pain at the same time. For example, the person might have pain caused by cancer, arthritic aches, and neurogenic pain due to diabetic neuropathy. Tylenol might help the arthritic pain - and drugs such as Neurontin can alleviate nerve pain. Then the person may require less opioid medication to relieve the cancer-related pain.

5. Consult with the long-term care pharmacist or hospice, if appropriate, about pain management. Hospice providers are pain management experts and usually more than willing to share some tips for handling tough pain problems. In addition, "the pharmacist can work with prescribers to ensure the most effective analgesics are used," says pharmacist **Tom Clark** with the **American Society of Consultant Pharmacists**.

6. Implement and evaluate various non-pharmacological interventions. The interdisciplinary team should individualize non-drug interventions, such as massage, diversion and companionship. Don't overlook the role of spiritual support.

"The clergy person may be the only person who sits down with the patient for 30 minutes or more and just listens, so the patient may be willing to discuss her pain and related psychological and spiritual issues," Nichols says.