



PARRI NEWS

The Pennsylvania Restraint Reduction Initiative

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Pain Management in Long Term Care

Quality pain management for elderly patients and residents is an initiative that is long overdue. *The American Geriatrics Society (AGS): Panel on Persistent Pain in Older Persons*, June 2002, emphasized the fact that persistent pain is common in older people and that the healthcare system has an obligation to provide comfort and pain management for older patients. Unfortunately, these findings are not new. The fact that many of the same system-wide barriers and challenges to effective pain management were identified in the 1998 AGS report speaks volumes about the failure of health care professionals to address this problem.



A team approach at St. Annes Home in Columbia, Pa.: (l-r) Karen Kuhn, Restorative Coordinator, Sharon Nolte, DON, Fran Urban, RN, and Coleen Kayden, Consultant Pharmacist, review the care plan and interventions to evaluate a resident's response to a pain management regimen.

It is a constant source of frustration to me, as a consultant pharmacist, to observe a resident with verifiable persistent pain continuing to receive pain medications that are either prescribed inappropriately or administered inappropriately, or both. There are numerous credible sources for best practices in pain management, including the AGS 2002 Guidelines, the American Medical Directors Association (AMDA) 1999 Guidelines, and the American Pain Society among others. There is strong, consistent evidence from all of these sources to support the use of certain classes of analgesics and to avoid the use of other classes of analgesics when treating older persons. In a 1999 article for the *Journal of the American Society of Consultant Pharmacists*, "Aging as a Risk Factor for Medication-Related Problem," Dr. Mark Beers discusses in detail which medications present undesirable outcomes in the elderly. Yet, I see daily evidence of these very medications utilized for my residents. There is strong, consistent evidence from all of these sources to support the use of scheduled dosing for persistent pain; yet I see daily evidence of PRN orders. It is particularly unreasonable and inappropriate to expect residents with cognitive impairment to "ask" for medication for pain relief.

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ROUTE TO:

- DON
- RNAC
- CNAs
- Social Service
- Activities
- Rehab
- Staff Development
- Dietary
- Administrator
- Other

Pain Management in Long Term Care—continued from page 1

The Lancaster County Long Term Care Pain Task Force was formed in response to these very concerns. The goal of the task force is to identify and institutionalize best practices in pain management in Lancaster county facilities. As might be expected, the first part has been relatively easy. Institutionalizing best practices, however, has been a far greater challenge and must be approached on many levels.

First, and most important, is education—education concerning the impact of pain on the resident, the staff, and the facility itself; education concerning proper assessment and appropriate intervention; and education concerning valid measurement tools and effective documentation.

Interestingly enough, an effective, user-friendly *daily* assessment tool has been one of our biggest challenges. The MDS, while important, only provides a snapshot of the resident's pain. There are many pain assessment tools available, but they are designed for intermittent use. We have collectively agreed that daily, ongoing assessment and reassessment of pain management is warranted. Without it, we will continue to have residents in pain, even treated for pain; but we most certainly will not have residents' pain managed.

Second, and equally important, is communication. One of the most effective things we can do in pain management is to make it easy for all involved to do the right things and very difficult to do the wrong things. Appropriate communication skills are an integral part of making it easy to do the "right thing." Calling a physician at 1 A.M., for example, to report that Mrs. Smith is again complaining about her back, and asking in an open-ended way what she/he wants to do does not encourage the appropriate response. Alternatively, calling a physician at 1 A.M. to say that Mrs. Smith is reporting increased back pain unrelieved by her current dose of acetaminophen, heat packs, repositioning, and one-to-one attention, and that the current protocol suggests that we use XYZ pain medication for relief until you can assess her, has a far better chance of encouraging a more appropriate response.

One example of the importance of education and communication involved a resident with dementia living on a secure unit in a local facility. He had become increasingly combative with care, withdrawn at times, unable to engage in activities, and was refusing food. Psychoactive medication failed miserably and only served to make him more lethargic. A complete pain assessment was done, a detailed history reviewed, and an opioid regimen initiated. He responded beautifully. His activity level improved so much that the administrator stopped me in the hall to ask what we had done to achieve such a positive response in the resident. This resident remained active and in good overall spirits for several months. Then his attending physician retired. His new physician was "appalled" that this resident was on high dose opioids and began tapering his doses. Unfortunately, this was done without consulting our behavior/pain management team. The unit nurse simply followed the physician's orders. The results were predictable. It was several weeks before we were able to convince the physician to restore the opioid regimen. There is no doubt in my mind that the physician believed he was serving the resident's best interests; but in retrospect, we made it too easy for him to do the "wrong" thing.

It is impossible to identify all of the systemic issues involved in institutionalizing pain management. I have highlighted only two of them. It is important, however, that whatever the obstacles, they must be identified and overcome. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has made pain management a resident rights issue. The Centers for Medicare and Medicaid Services (CMS) now includes pain management in the Quality Indicators. The American Geriatric Society has twice conducted a panel on persistent pain in the elderly. We in Lancaster County recognize that despite the presence of the task force, there is still plenty of education needed by practitioners and caregivers alike; and so our work continues.

Coleen M. Kayden, R.Ph, is a Pharmacy Consultant with Medication Information Services, a Division of Williams Apothecary, Inc., in Lancaster, PA. You can reach her at 717-393-3814 or by e-mail, ckayden@wmsapoth.com



I Know My Resident Is in Pain When. . .

Through my work with the Pennsylvania Restraint Reduction Initiative, I have had the opportunity to meet many dedicated nurses and caregivers. Knowing that this edition of the PARRI News was going to focus on pain, I thought it might be interesting to ask for staff responses regarding ways that residents have demonstrated pain. Some of the replies shared with me were unique reminders that we should always pay close attention to what our residents are telling us, even when they aren't speaking.

Karen Russell
PARRI Regional Director

The following are responses to the statement, **"I know my resident is in pain when. . ."**

◆ "I notice how they hold their bodies. I often see clenched fists and stiff upper body positioning. I notice the 'death grip' that residents will use to hold onto chairs or staff or whatever they can grab. This positioning may be their response to an uncertain situation, but frequently they are experiencing pain and are trying to protect themselves from additional discomfort."

Pat Slaughter, OTR

◆ "One of my residents will neatly pile up his food. This guy is usually a very good eater and he feeds himself. We started to notice this behavior and it became more frequent. There was nothing else that was different; he would just start piling up the food. One of the nurses gave him some Tylenol one day and we noticed about an hour later he was digging around in the food cart that was filled with empty trays and discarded food. We got him a fresh tray from the kitchen and he ate everything. The next time he started to pile up his food he got the Tylenol right away and then we got a tray for him about a half hour later. He has been eating well since. I don't think we ever figured out if he was having headaches for sure, but something was bothering him." Brian C. White, CNA

◆ "I remember caring for a resident who was always trying to get himself on the floor. We often witnessed him putting himself there so we knew he was not falling. He did it around the clock. There was no pattern to this behavior and once he was on the floor he looked very contented. A group of staff brainstormed and he was provided with some type of back brace, a firmer mattress, and he was started on some very mild and routine pain medication. After that, his trips to the floor were significantly decreased." Jackie Kollar, LPN

◆ "We currently have a resident who taps lightly on her forehead with her fingertips. She doesn't seem in

distress when she is doing it, so initially we didn't act on it. Now we have recognized this as her way of letting us know she wants something for discomfort. When she gets her Tylenol, the tapping stops." Debi Rodermoyer, LPN

◆ "I noticed one of my residents behaving differently at mealtime. She began to shove her bread in her mouth and pocket it in her cheek. Initially, this went on for about one week. We took her bread away from her because we were afraid she would choke. We then discovered she was running a low-grade fever and we began to notice some swelling of her face. It turned out she had an abscessed tooth. Looking back, we think she was putting the bread in her mouth to comfort or protect her tooth." Barb Tillen, CNA

◆ "Working in speech therapy, I think I have a tendency to read what the face is telling me. I often suspect pain when I see clenched teeth and facial grimacing. I know that people might say, 'Well, that's obvious.' But more often it's looked at as stubbornness or a protest to eating. It is important to assess this resistive behavior. A comfortable resident is more likely to be a better eater." Cindy Mason, SLP

◆ "A few years ago I cared for a man who would wheel himself to a sunny window and spend the better part of the day there. He started to demonstrate some restless, angry behaviors on the days he was not at the window. One of the housekeepers would try to joke with him about whether he was going to 'get any tanning in today.' She was right in recognizing that he was only at the window on sunny days. We wondered if he was getting comfort from the warmth of the sun. We got an order for a topical analgesic that we started to use when he would act out. Sometimes we also gave Tylenol. The result was a much happier resident." Lynn Mahler, RN

◆ "We recently had a resident who began to demonstrate behavior that was unusual for her. She would lean forward in her chair and was very restless, making repeated attempts to stand. Utilizing a routine mild analgesic and a rocking chair periodically throughout the day really solved the problem." Amanda Ott, RN

If you would like to respond to the question, "I know my resident is in pain when..." or if you have a story or description of a resident in pain that you'd like to share with readers of our newsletter, please send to: Karen Russell, PARRI, The Kendal Corporation, P.O. Box 100, Kennett Square, PA 19348 or by e-mail, krussell@kcorp.kendal.org



A Compendium of Fall Prevention Ideas

What We're Doing to Reduce Falls: A Letter from a Reader

Thanks for such a helpful column in the last issue of *PARRI News*. We are a 453-bed facility that reduced our falls incidence by 19.8% last year. We used many of the interventions listed by Pixie Wilder in your last newsletter (*PARRI News*, V. 3, No. 3, Winter 2002) and I am intending to use more from that list. Here are some of our successful interventions:

Facility-wide interventions include:

- 1) Each unit has a unit-based interdisciplinary fall prevention team that meets weekly to discuss resident falls during the past week. They review the current interventions and suggest others. They also identify resident and unit trends and develop action plans to address them.
- 2) Each unit keeps a *Fall Alert* list of residents who are at very high risk: frequent fallers (60 days), new admissions (72 hours), and any residents who have had a fall with injury (60 days) are included. All staff are responsible for checking the list daily and being aware of interventions for the residents on the list.
- 3) We have developed a *Fast Facts on Falls* sheet that covers fall-related subjects that can be used at staff meetings or given out to staff. The information has kept fall prevention in front of the staff on a regular basis.
- 4) A list of interventions (200 and growing!) is kept on each unit and updated regularly. The list can be referenced whenever new interventions are needed.
- 5) We have asked our bed and chair alarm vendor sales representative to inservice our staff on use, care, and indications for personal alarms.

Resident-specific interventions include:

- 1) Encourage residents to wear non-slip socks while in bed at night to prevent slipping if they get out of bed, especially for residents who may forget to put slippers on.
- 2) Use warm herbal pillows to calm agitation and restlessness. Some are shaped like a heart and are very easy to hug.
- 3) Use a sheet of anti-slip material placed on the seat of a wheelchair for a resident who tends to slip out of his/her chair.
- 4) Several restless residents who are resistant to other interventions have responded to regularly scheduled pain medication instead of prn. It is especially effective for residents who are unable to communicate their pain needs. Treating for pain has worked wonders!

5) Several residents benefit from OT evaluating their seating and making modifications for comfort. When needed, we use anti-tip devices and automatic brake locks.

6) Use pictures of a resident's wife to calm him when the resident is trying to find her. Also, offer the phone for the resident to be able to speak with her when possible.

7) Offer a Tai Chi group to improve the strength and balance of several residents who are at risk for falls.

8) Place an afghan, sweater, or other personal article across the resident's lap as a reminder to ask for assistance to rise from the chair. (Often, the resident does not want the article to fall on the floor.)

9) Wrap a resident's oxygen tubing with colored tape so she can see it better, to prevent tripping.

10) Place non-skid strips in the bathroom for residents who have fallen at the sink or toilet.

11) Replace two- to three-inch thick traditional floor mats next to bed with thinner, flatter "space mats" with beveled edge. They are safer for both residents and staff, and just as effective for cushioning falls.

12) Offer a grabber device to a resident attempting to reach for things. Viola! No more falls.

It's critical to empower the entire staff to participate in fall prevention solutions and interventions, not just the management team. I have also found that fall prevention needs to be kept in front of the staff on a regular basis. Monthly fall statistics for the facility are shared with all staff, along with any trends found in the data which might indicate continued actions.

Thanks again for a great resource.

Jo Ann Hart, RN MSN, is Clinical Project Manager at Masonic Homes in Elizabethtown, PA. You can reach her at (717) 367-1121, ext. 33527 or by e-mail, jhart@masonichomes.org.

Editor's note: We plan to offer this column as a regular feature of the newsletter, and we would be pleased to publish your fall prevention/safety awareness ideas. Please send them to Neil Beresin, PARRI, The Kendal Corporation, P.O. Box 100, Kennett Square, PA 19348 or by e-mail, nberesin@kcorp.kendal.org



Web Site Resources

Pain and Pain Management in Vulnerable Elders

In each edition of the newsletter, the editor plans to offer a list of web resources addressing specific diseases, care, or organizational issues. It is hoped the resources will promote new approaches and strategies in the spirit of providing individualized resident-centered care without the use of physical restraints. Please note that listing the web resources does not constitute an endorsement or recommendation by the Pennsylvania Restraint Reduction Initiative of any particular web site or product. If you have a specific topic you would like to see addressed, or if you have a specific web site that you have found valuable to your daily work, please send to: Janet Davis, PARRI, The Kendal Corporation, P.O. Box 100, Kennett Square, PA 19348 or by e-mail, jdavis@kcorp.kendal.org.

The prevalence of pain in residents of nursing homes has been reported to be between 45 and 80%.¹ For such a large percentage of institutionalized elders to be without proper pain relief is inexcusable and unnecessary. Nurses and caregivers need to pay particularly close attention to residents who have diminished communication skills, memory loss, cognitive impairment, or dementia. The most frequent sign of pain in elders with mid- to late-stage dementia is often one or more of the following: tense body language, sad facial expression, persistent verbalizations, or verbal outbursts.² Pain manifests itself in other ways as well: irritability, constant reaching for items to hold, anxiousness, anger, lack of motivation, depression, and sleepiness, for example. We also know that many care-related issues, particularly behavioral challenges and increased risk of falls, can be a direct result of unrecognized pain.

¹ Ferrell, BA. Pain evaluation and management in the nursing home. *Annals of Internal Medicine*, 123:681-687, 1995.

² Kovach, C.R., Weissman, D.E., Griffie, J., Matson, S., & Muchka, S. Assessment and treatment of discomfort for people with late-stage dementia. *Journal of Pain and Symptom Management*, 18:412-419, 1999.

<http://www.medscape.com/viewarticle/416593>
The Complexities of Geriatric Pain Management.
Karen Shapiro, PharmD.

<http://www.ascp.com/public/pr/guidelines/painrecognition> Guidelines for Recognition and Assessment of Pain in Older Adults, ASCP American Society of Consultant Pharmacists.

<http://www.mmhc.com/cg/articles/CG0207/aapm.pdf>
Cultural Influences on Pain Management in the Elderly.
Kenneth Sakauye, MD.

http://www.americangeriatrics.org/products/chronic_pain.pdf The Management of Chronic Pain in Older Person. AGS Panel on Chronic Pain in Older Persons. May 1998-Vol 6 No 5 JAGS.

<http://www.painfoundation.org>
American Pain Foundation

http://www.merck.com/pubs/mm_geriatrics/sec6/ch43.htm

The Merck Manual of Geriatrics-Pain.

<http://www2.edc.org/lastacts/archives/archivesJan01/featureinn.asp>

Improving Pain Management in Long-Term Care Facilities.
David E. Weissman, MD, Julie Griffie, RN, MSN, CS, AOCN, CHPN, Sandra Muchka, RN, MS, CS, CHPN, Sandra Matson, MA, RN, C.

www.vrri.org/rhb0300.htm

“Recognizing Pain: Why Medical Personnel May Misinterpret Pain Cues.”

<http://www.annals.org/issues/v135n8s/pdf/200110161-00012.pdf> Quality Indicators for Pain Management in Vulnerable Elders. *Annals of Internal Medicine*, October 2001, Volume 135, No 8.

<http://www.mmhc.com/nhm/articles/NHM0009/feldt.html> Improving Assessment and Treatment of Pain in Cognitively Impaired Nursing Home Residents. Karen S. Feldt, PhD, RN, CS, GNP.

http://www.nursinghome.org/pro/frmNewsletter.asp?strFile=/pro/newsletters/closeup_new/2001/cu0436.html

Helping Residents with Pain: The Important Role of Activities. Kevin M. Kavanaugh, MA, Illinois Council on Long Term Care. August 31, 2001 - Number 436.

http://www.nursinghome.org/pro/frmNewsletter.asp?strFile=/pro/newsletters/closeup_new/2001/cu0437.html

Helping Residents with Pain: The Important Role of Activities-Part II. Kevin M. Kavanaugh, MA, Illinois Council on Long Term Care. September 7, 2001-Number 437.



Artman Lutheran Home:

Newest PARRI Physical Restraint Reduction Training Site



Artman Lutheran Home's Restraint Reduction Team: (l-r) Dot Craven, PT, Janet Lorenzon, NHA, Kim Biletz, ADON, Karen Cassel, Recreational Therapy, Heather Nace, Director of Social Services, Dana O'Donnell, DON. Not pictured: Jackie Burleigh, Resident Care Coordinator, and Mona Mack, CNA.

The Pennsylvania Restraint Reduction Initiative (PARRI) is pleased to welcome the Artman Lutheran Home in Ambler as the newest physical restraint reduction training site to join the project. The Restraint Reduction Team at Artman has had its sights on becoming a training site since 2001, and has worked hard to achieve its goal. Dana O'Donnell, Director of Nursing, commented, "We wanted to provide our residents with the healthiest and safest environment, and eliminating physical restraints and side rails has been vital to helping us accomplish this goal. To be a training site, we had to commit ourselves to a process that we felt would ultimately improve our residents' lives. And it has. Now that we're a training site, we feel that it will help us build a closer relationship to surrounding nursing homes, and perhaps others can learn from our experience."

Congratulations to Artman Lutheran Home!



News Notes



PARRI training team members, Sara Wright and Neil Beresin presenting at NCOA/ASA conference, Chicago.

✓ On March 15, 2003, the PA Restraint Reduction (PARRI) training team presented the program **The Pennsylvania Restraint Reduction Initiative: The Keystone Uniting Successful Restraint Elimination** at the joint National Council on Aging/American Society on Aging (NCOA/ASA) conference in Chicago.

✓ On April 16, 2003, Janet Davis, PARRI regional director, presented an update on the Pennsylvania Restraint Reduction Initiative at the Pennsylvania Association of County Affiliated Homes (PACAH) Conference in State College.

✓ On May 16, 2003, Sara Wright of the PARRI training team, and Lori Eckberg, Laura Hamm, and Cindy Anderson of Windy Hill Village of the Presbyterian Homes, Philipsburg, presented the program **Anecdotes From a Partnership: Building a Psychotropic Medication Review Training Program** at the Lifespan/PANPHA conference in Baltimore. The presentation featured elements in building an effective psychotropic medication review process and development of a training program.

✓ The PARRI training team's proposal, **Falls Got You Down? Building an Effective Fall Management Process in Long Term Care**, was accepted by the American Association of Homes and Services for the Aging's (AAHSA) 2003 Annual Meeting and Exposition to be held in Denver in October 2003.

✓ The PARRI team has compiled a new resource tool entitled **Assessment Tools and Guidelines for Nurses and Caregivers**. The 105-page book includes Bed Safety/Rails, Behavior Management, Environmental Safety, Fall Prevention, General Nursing, Medication Monitoring, Monitoring Devices, Pain, Restorative Nursing, Restraint Elimination, and Seating. To obtain a copy, contact Mary Scharf at 610-388-5580 or by e-mail, mscharf@kcorp.kendal.org

Upcoming Activities

✓ On May 29, 2003, Sara Wright of the PARRI training team and Coleen Kayden, Pharmacy Consultant, will co-present a one-day workshop, **Moods, Behaviors & Psychotropic Medications: Building a Balanced Review Process**, in Hershey.

✓ Beginning June 2003, the PARRI training team will offer a full-day regional program, **Back to Basics**. Targeted to all long-term care staff, **Back to Basics** is designed to help facilities with their approach to management of restraint and siderail reduction, behaviors, medications, and falls. The program will be offered in the Pittsburg, Erie, Allentown, Bethlehem, Lewisburg, and Williamsport areas. Watch for announcement flyers. For more information, contact Mary Scharf at 610-388-5580 or by e-mail, mscharf@kcorp.kendal.org

✓ In August 2003, Karen Russell of the PARRI training team and staff from Windy Hill Village of the Presbyterian Homes, Philipsburg, will present a program on culture change at the Pennsylvania Culture Change Conference in Harrisburg.



The Pennsylvania Restraint Reduction Initiative training team provides services to all Pennsylvania nursing facilities striving to deliver quality care to their residents. Do not hesitate to contact any member of the training team for assistance.

Neil Beresin, Regional Director, 215-844-6139 or
nberesin@kcorp.kendal.org (eastern region).

Janet Davis, Regional Director, 610-268-6929 or
jdavis@kcorp.kendal.org (central region).

Karen Russell, Regional Director, 814-375-6011 or
krussell@kcorp.kendal.org (western region).

Sara Wright, Geriatric Nurse Practitioner, 610-683-5839 or
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