10 Paradigm Shifts about Responsive Behaviours & Pain

Pain & Mood Project
Why are Residents in Pain?
• Distressed mood & depression
• Immobility: musculoskeletal
• Joint inflammation
• Dental pain, ear wax impaction
• Mismatch: analgesic type/dose/frequency
• Medication side effects e.g.:
  • Muscle & nerve pain – statins
  • Constipation – anticholinergics
  • Urinary retention – anticholinergics
  • Acid reflux – anticholinergics
  • Delayed wound healing – PPIs
Why Worsening Depressive Mood?

- Pain (80% of residents!)
- Causes of distress not addressed

Antidepressants don’t treat:
- Medication side effects
- Frustration with unit routines (e.g. sleep interruptions)
- Unmet needs
- Social isolation
- Boredom
- Grief & loss

Depressive Mood as measured by MDS RAI

1. Negative statements
2. Persistent anger
3. Expression of unrealistic fears
4. Repetitive health complaints
5. Repetitive anxious complaints
6. Sad, pained, worried facial expression
7. Crying, tearfulness
Goal: Enhance person-centered care planning process for persons with pain and depressive mood in LTC and DSL

Measures of Success:
• Depression Rating Scale
• Residents experiencing pain
• Worsening pain and depressive mood
• Appropriate use of antipsychotics
• Fewer residents on 9+ medications
• Improved compliance CCHSS Standard 1
6% meet Standard 1
Communicate & Document

Notice change

Assess

Care Plan

Short term Intervention

Provide Care

Communicate

Assess
How to shift from regulation-focused to person-focused care?

Beliefs

Behaviours

Regulate: Policies, Forms, Standards

Outcomes
Beliefs drive outcomes

Beliefs
- Wet bed in morning = poor care at night
- Day shift will be mad at me

Behaviours
- Scheduled continence care

Outcomes
- Low mood
- Daytime drowsiness
- Aggression
- Falls
- Sedatives
Beliefs
Wet bed in morning = evidence of hydration and undisturbed sleep

Behaviours
Minimize interruptions & noise
Increase activity in day

Outcomes
Well-being
Improved mood
Less pain
Fewer falls
Fewer medications

CCHSS Standards Exceeded
Quality Improvement: *The Secret Sauce*

- **Awareness:** What is the shift in belief?
- **Desire:** Hope that change is possible & easier!
- **Knowledge:** What do we need to understand to do things the new way?
- **Ability:** What new skills or processes will support changes in behaviour?
- **Reinforcement:** How to make it easier to do things the new way?
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#1 Depressive Rating Scale (DRS) correlates with standardized depression assessment tools e.g. Cornell Scale for Depression in Dementia, Geriatric Depression Scale

The DRS is NOT a valid depression assessment.

Instructions for Cornell Scale:
- Assesses a consistent, licensed assessor
- No score should be given if symptoms result from physical disability or illness
- Assumes a single assessment looking back on the week – not once per shift
54% of LTC Residents on Antidepressants - Risks:

- Falls
- Dizziness
- Nausea
- Weakness
- Insomnia
- Anxiety, anger

- Stomach upset
- Constipation / diarrhea
- Heart problems
- Hyponatremia
- Worsening symptoms of other diseases
Indicators of Depression, Anxiety and Sad Mood
Alberta LTC Resident Profile 2016/2017

- Crying, Tearfulness
- Expression of What Appears to be Resident Makes Negative Statements
- Repetitive Health Complaints
- Repetitive Anxious...
- Persistent Anger with Self or Others
- Sad, Pained, Worried Facial...

Exhibited daily in past 30 days (%)
Exhibited at least once in past 30 days (%)
#2 Depressive Mood symptoms are “just the way they always are”. Only a specialist or pill can help.

- **DRS symptoms can be signs of distress – investigate and address**
#3 Pain is best managed with analgesics

- When we reduce distress, we also improve pain
- Supportive and non-pharmacologic strategies can help both pain and distress
#4 Assessing pain and distress in older adults with dementia is complex and difficult

- Common and predictable factors can be determined on admission or managed with proactive routines e.g. mobility, comfort rounds
#5 There is a “right” tool, consult team or form for assessing pain in older adults with dementia

- Pain assessment is an interdisciplinary process; treatment and support is multi-factorial

Consider:
- Ask the resident and family about pain
- Seating & sleeping surfaces
- Analgesic timing/dose/type
- Medication side-effects
- Sleep
- Nutrition
The best way to track pain is with a pain tracking tool.

- A huddle or behaviour map may be a more effective way to demonstrate improvement for persons with dementia.

When possible, self-reported pain is the gold standard.
#7 The goal of pain management is zero pain

- The goal of pain management is improved comfort, demonstrated by ability to sleep, eat, move and enjoy activities
#8 Assess interventions regularly e.g. quarterly/yearly or with significant change

- Assess interventions for effectiveness in first 48 hours to 1 week
- Learn from what does or doesn’t work
- Notice distress early

![Graph showing DRS over 14 Weeks with MDS Assessments]
RAI documentation is a time-consuming requirement

Attention to RAI accuracy can save time; can both drive and demonstrate quality improvement

- Is tracking by HCAs accurate?
- Is MDS data entered by someone who knows the resident?
- Do care plan interventions improve resident mood and well-being?
- Do families feel relieved?
- Are unnecessary hospitalizations & medications avoided?
- Does CMI reflect staffing needs?
#10 Improved care requires more people and resources

By doing fewer non-value-added activities, we can free time to improve well-being

Consider:
- 1-2 main med passes per day vs 5-6 per shift
- Fewer medications
- Efficient information transfer at shift change
- Functioning equipment
- Location of supplies
Digital Stories: change is possible, new ways can be easier

The Good Daughter

The Big Leap

Care Assignments
Graphic Resources

- Celebrate exemplary sites
- Model effective quality improvement
- Demonstrate the way forward
- Support engagement
What are participants learning?

• Assessment, treatment & supportive strategies: Pain & DRS
• Appropriate prescribing & medication optimization
• Person-centered care planning process: Identify gaps e.g.
  ✓ 1.2 Does the care plan reflect the assessment?
  ✓ 1.3 IDT assessment to address physical, mental, emotional, intellectual and spiritual health care needs and corresponding goals
  ✓ 1.5 Is the client or their agent involved in development?
  ✓ 1.8 Are interventions working?
Team Action Planning

Plan to improve pain and mood with new ideas!
Quality Improvement: Resident Comfort & Mood

- Residents triggering DRS or pain
- Coding accurate?
- Care plan goal & intervention?
- Resident &/or agent involved?
- Intervention effective?
Pain & Mood website

Suites of resources e.g.
- Family & resident council presentation
- Presentations for leaders & care teams
- Digital story
- Graphic resource
- Physician engagement
- Strategy checklist
- Staff education
- Posters
- Links to other web resources

Topics:
- Consistent care assignment
- Appropriate medication use
- Person-centered therapeutic recreation
- Support of sleep
- Nutrition & dining
- Other future topics
Keys to Success

Your priorities include:
- Pain, DRS
- CCHSS Std 1
- Responsive Behaviours
- Antipsychotic use
- Medication appropriateness

Leaders attend workshops and support action plans e.g. Site administrator, Unit manager, RAI lead (LTC), Case managers (DSL), Professional staff e.g. nursing, recreation, allied health, point of care staff e.g. HCAs

Communicate successes to your unit, facility and organization
- Quality board, newsletters, staff meetings, shift huddles
Next wave of workshops begins
May (LTC) and Oct (DSL)
More opportunities in 2021

Contact us
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