10 Paradigm Shifts about Responsive Behaviours & Pain

Pain & Mood Project

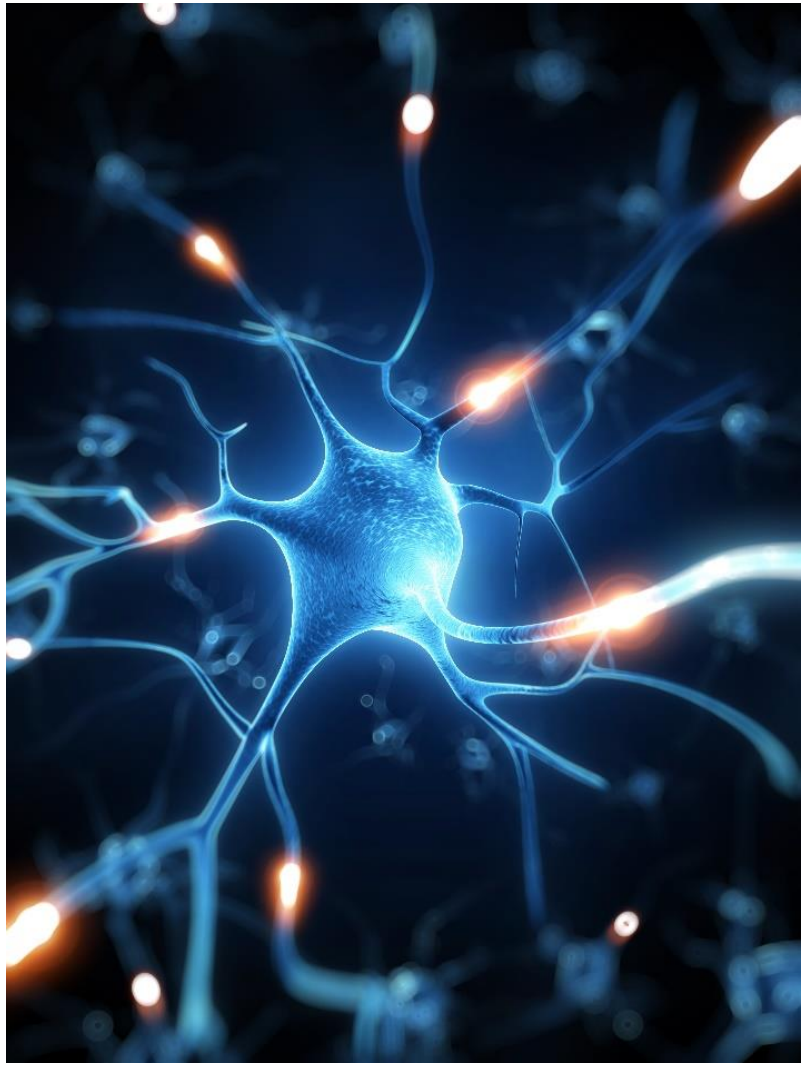
Alberta Health Services
Inspiring solutions. Together.

Seniors Health Strategic Clinical Network™

February 12, 2020

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:

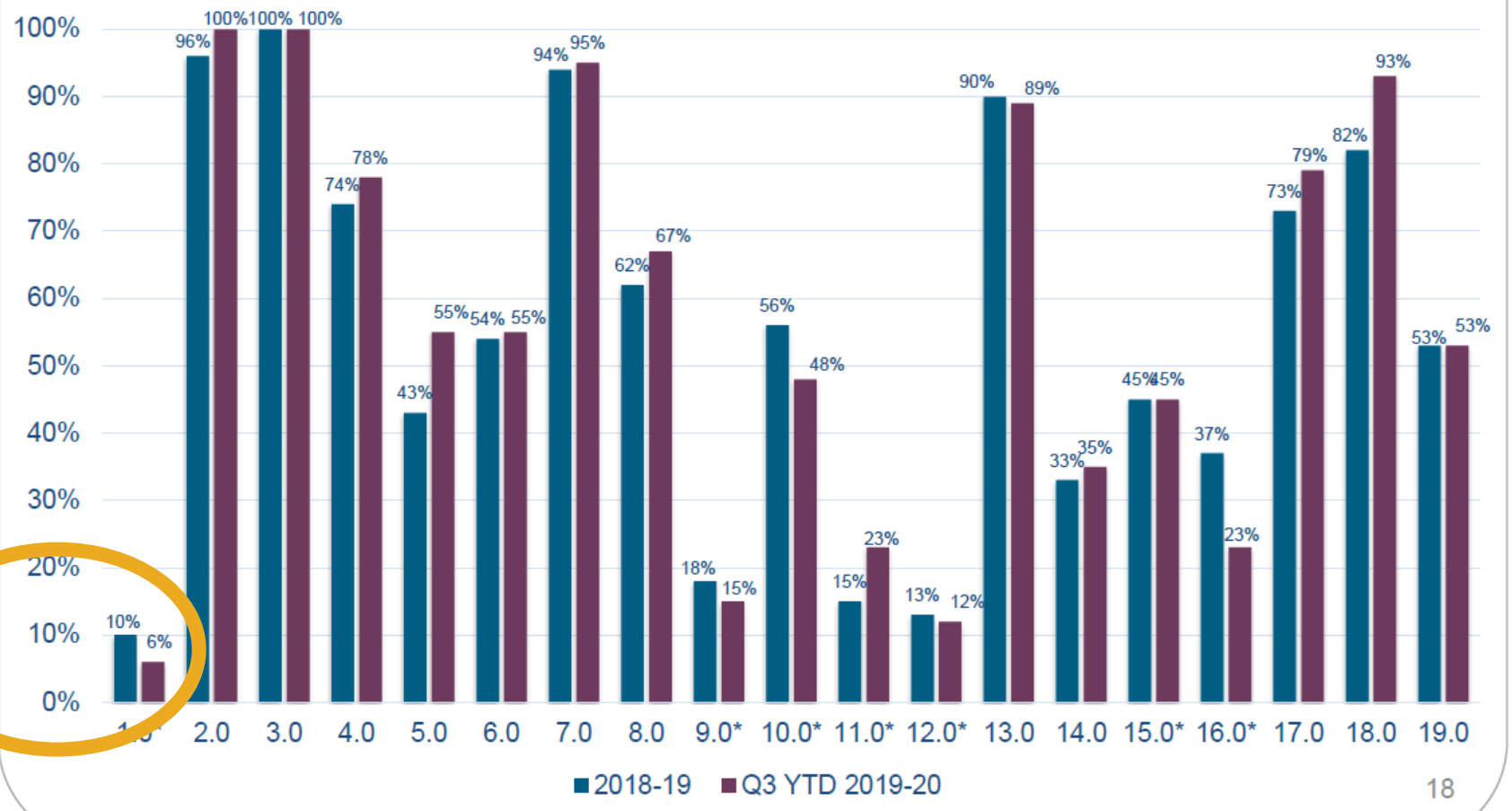
- Depression Rating Scale
- Residents experiencing pain
- Worsening pain and depressive mood
- Appropriate use of antipsychotics
- Fewer residents on 9+ medications
- Improved compliance CCHSS Standard 1

6% meet

Standard 1

Provincial Continuing Care Audit Team
YTD 2019-20 Results

Compliance by Standard 2018-19 and YTD 2019-20



Communicate & Document

Assess

Care Plan

Short term Intervention

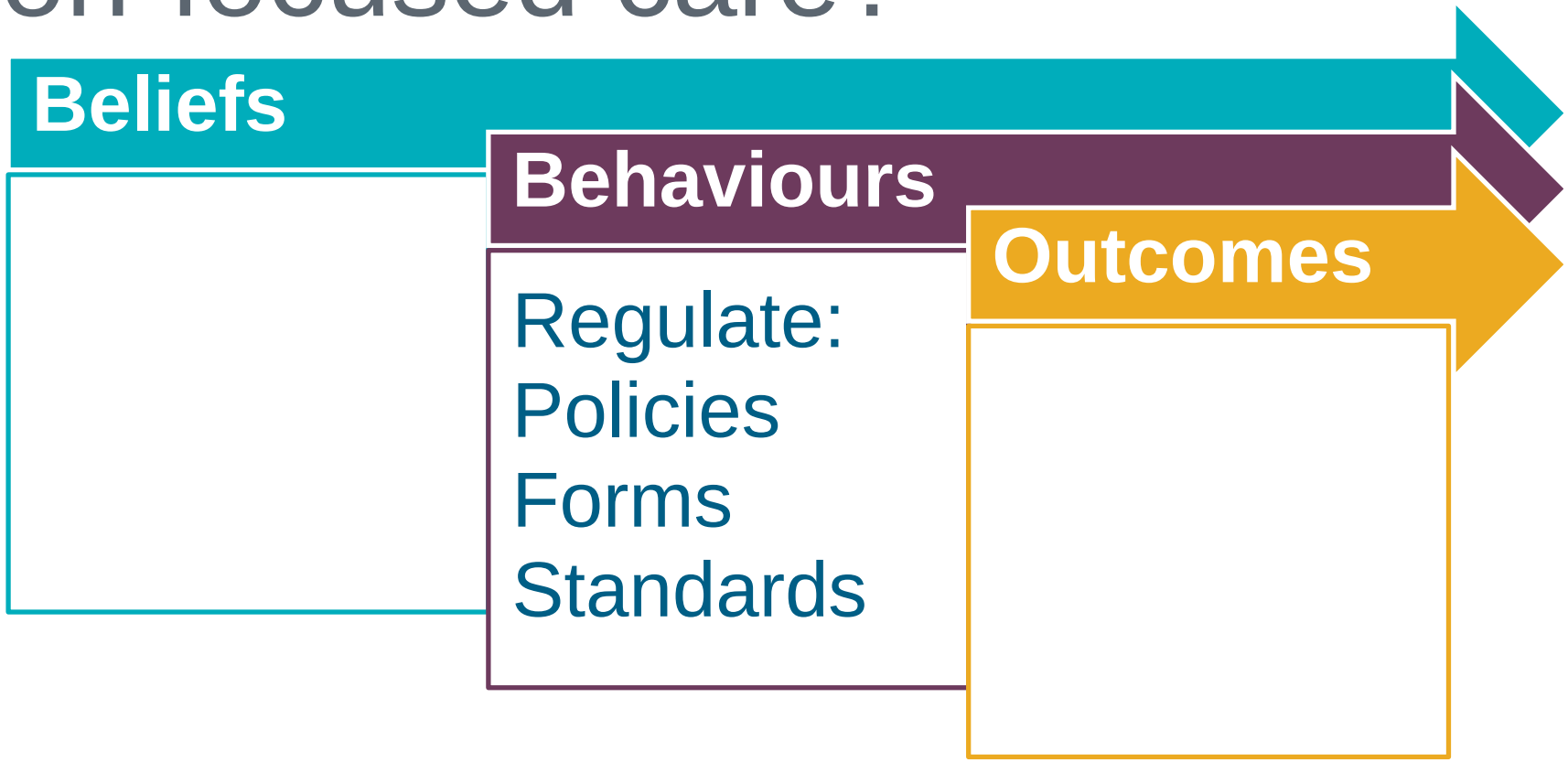
Commun icate

Provide Care

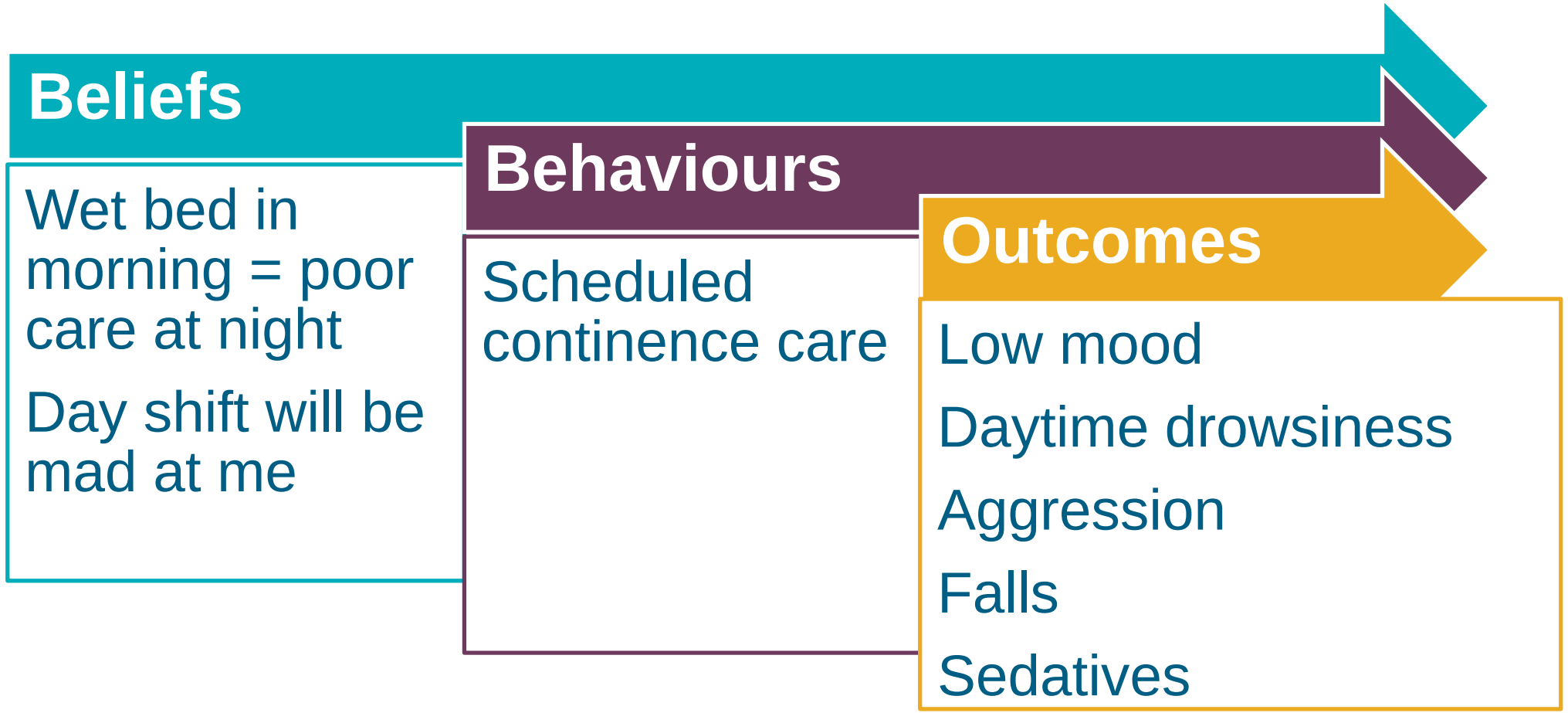
Notice change

Docu- ment

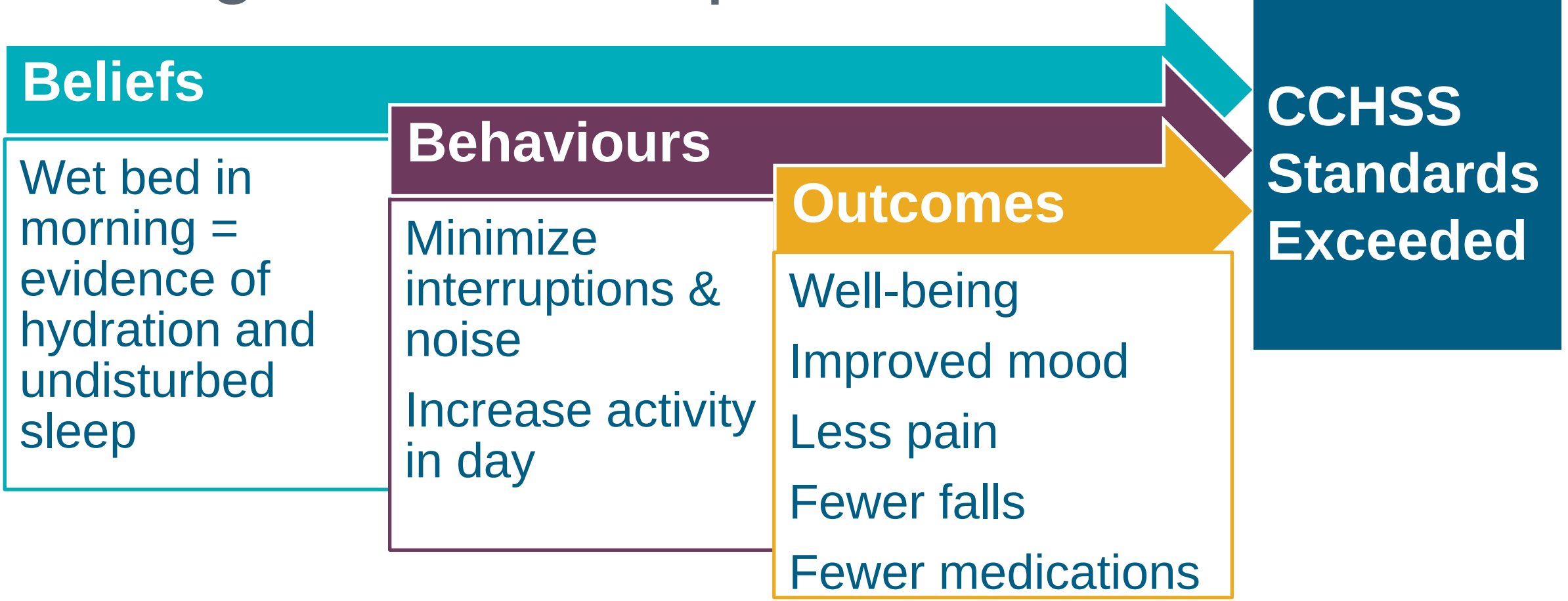
How to shift from regulation-focused to person-focused care?



Beliefs drive outcomes



Change beliefs, improve outcomes



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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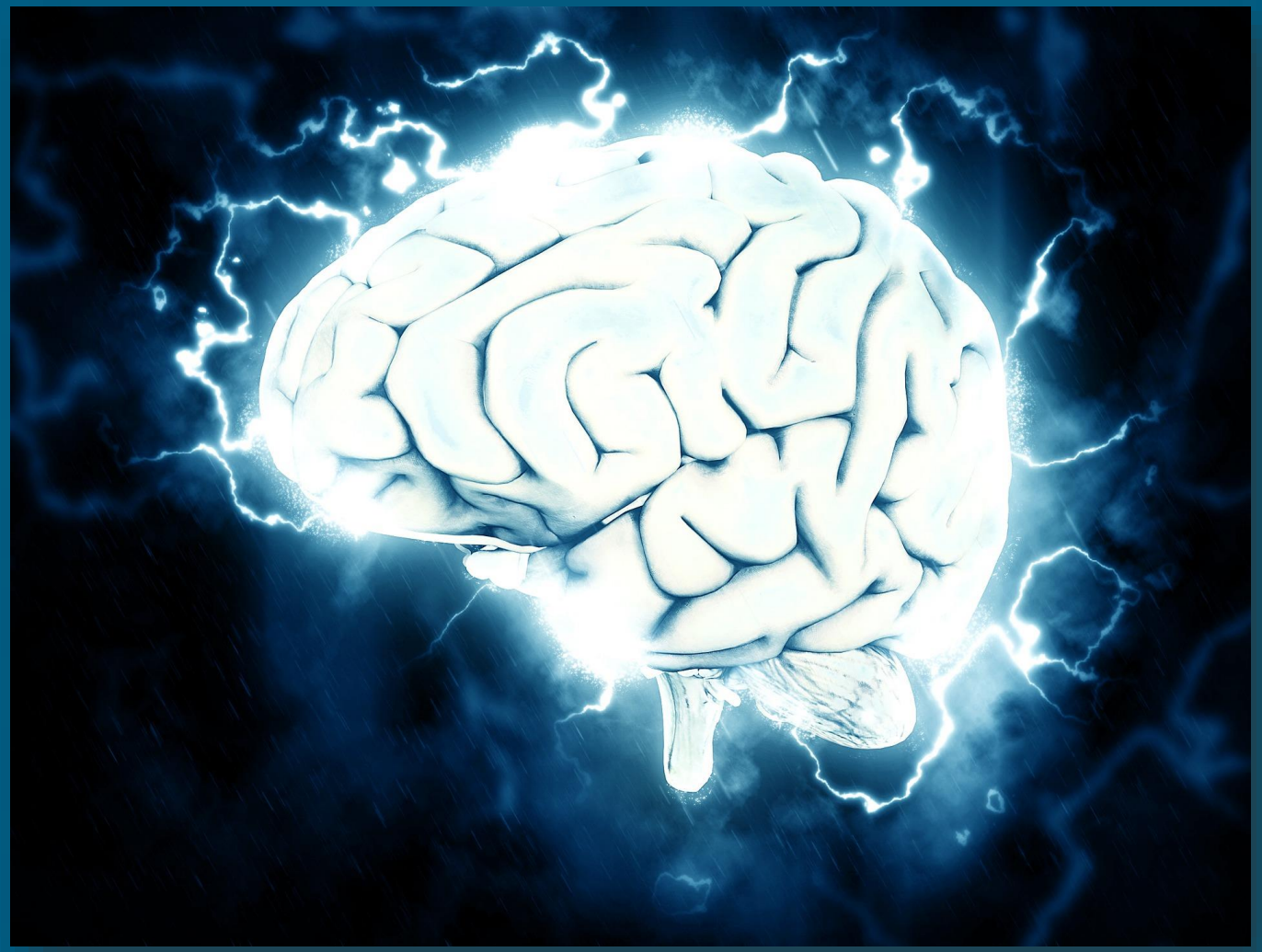

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#1 Depressive Rating Scale (DRS) correlates with standardized depression assessment tools *e.g. Cornell Scale for Depression in Dementia, Geriatric Depression Scale*

➢ ***The DRS is NOT a valid depression assessment.***

Instructions for Cornell Scale:

- Assumes 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

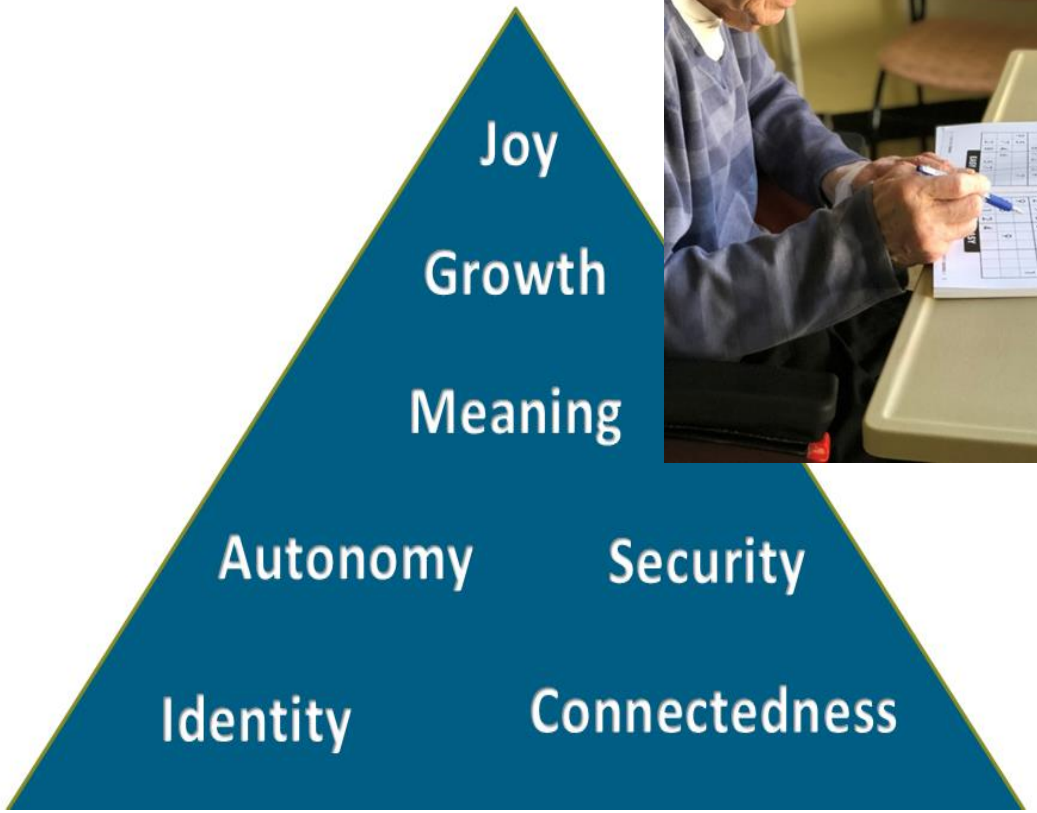
Indicators of Depression, Anxiety and Sad Mood
Alberta LTC Resident Profile 2016/2017

#2 Depressive Mood symptoms are “just they way they always are”. Only a specialist or pill can help.

- ***DRS symptoms can be signs of distress – investigate and address***

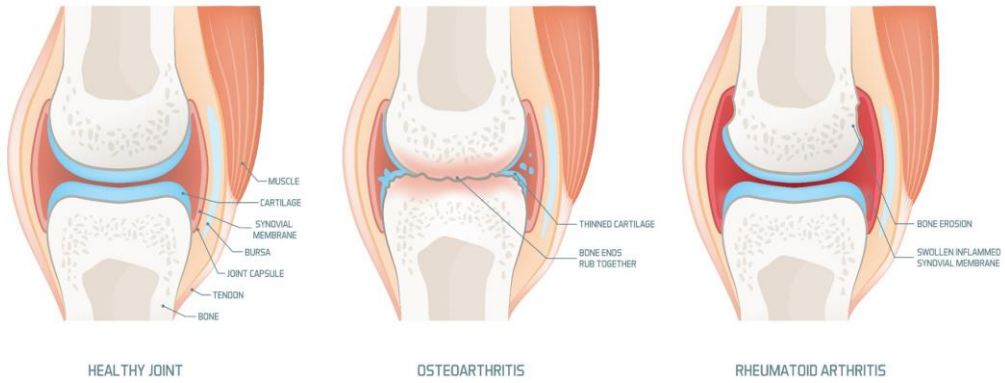
#3 Pain is best managed with analgesics

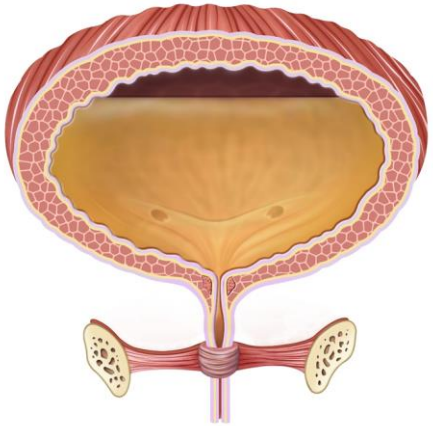
- ***When we reduce distress, we also improve pain***
- ***Supportive and non-pharmacologic strategies can help both pain and distress***



#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:

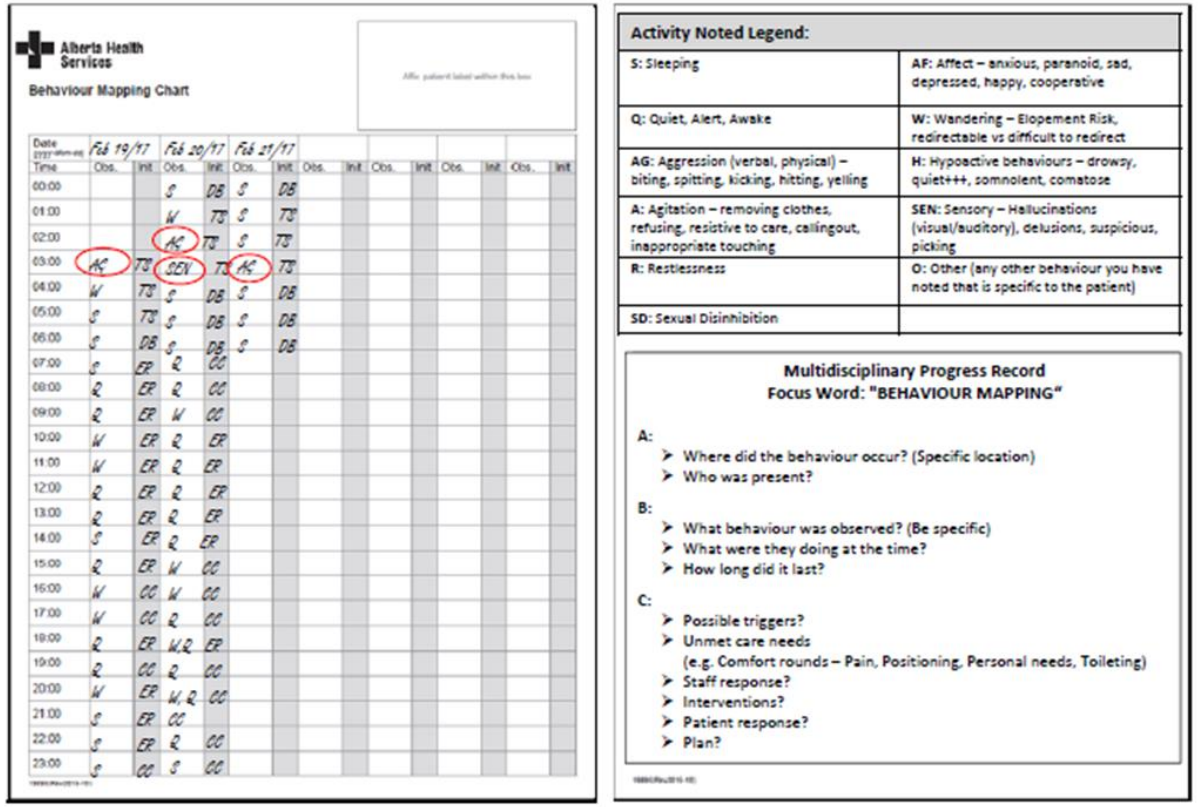
- Ask the resident and family about pain
- Seating & sleeping surfaces
- Analgesic timing/dose/type
- Medication side-effects
- Sleep
- Nutrition

#6 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.

Behaviour Mapping Process



Alberta Health Services

Behaviour Mapping Chart

Date	Feb 19/17		Feb 20/17		Feb 21/17									
Time	Obs.	Int	Obs.	Int	Obs.	Int	Obs.	Int	Obs.	Int	Obs.	Int	Obs.	Int
00:00			S	DB	S	DB								
01:00			W	TB	S	TB								
02:00			AG	TB	S	TB								
03:00	AG	TB	SEN	TB	AG	TB								
04:00	W	TB	S	DB	S	DB								
05:00	S	TB	S	DB	S	DB								
06:00	S	DB	S	DB	S	DB								
07:00	S	ER	R	CC										
08:00	R	ER	R	CC										
09:00	R	ER	W	CC										
10:00	W	ER	R	ER										
11:00	W	ER	R	ER										
12:00	R	ER	R	ER										
13:00	R	ER	R	ER										
14:00	S	ER	R	ER										
15:00	R	ER	W	CC										
16:00	W	CC	W	CC										
17:00	W	CC	R	CC										
18:00	R	ER	W,R	ER										
19:00	R	CC	R	CC										
20:00	W	ER	W,R	CC										
21:00	S	ER	CC											
22:00	S	ER	R	CC										
23:00	S	CC	S	CC										

Activity Noted Legend:	
S: Sleeping	AF: Affect – anxious, paranoid, sad, depressed, happy, cooperative
Q: Quiet, Alert, Awake	W: Wandering – Elopement Risk, redirectable vs difficult to redirect
AG: Aggression (verbal, physical) – biting, spitting, kicking, hitting, yelling	H: Hypoactive behaviours – drowsy, quiet+++, somnolent, comatose
A: Agitation – removing clothes, refusing, resistive to care, callingout, inappropriate touching	SEN: Sensory – Hallucinations (visual/auditory), delusions, suspicious, picking
R: Restlessness	O: Other (any other behaviour you have noted that is specific to the patient)
SD: Sexual Disinhibition	

Multidisciplinary Progress Record
Focus Word: "BEHAVIOUR MAPPING"

A:
- Where did the behaviour occur? (Specific location)
- Who was present?

B:
- What behaviour was observed? (Be specific)
- What were they doing at the time?
- How long did it last?

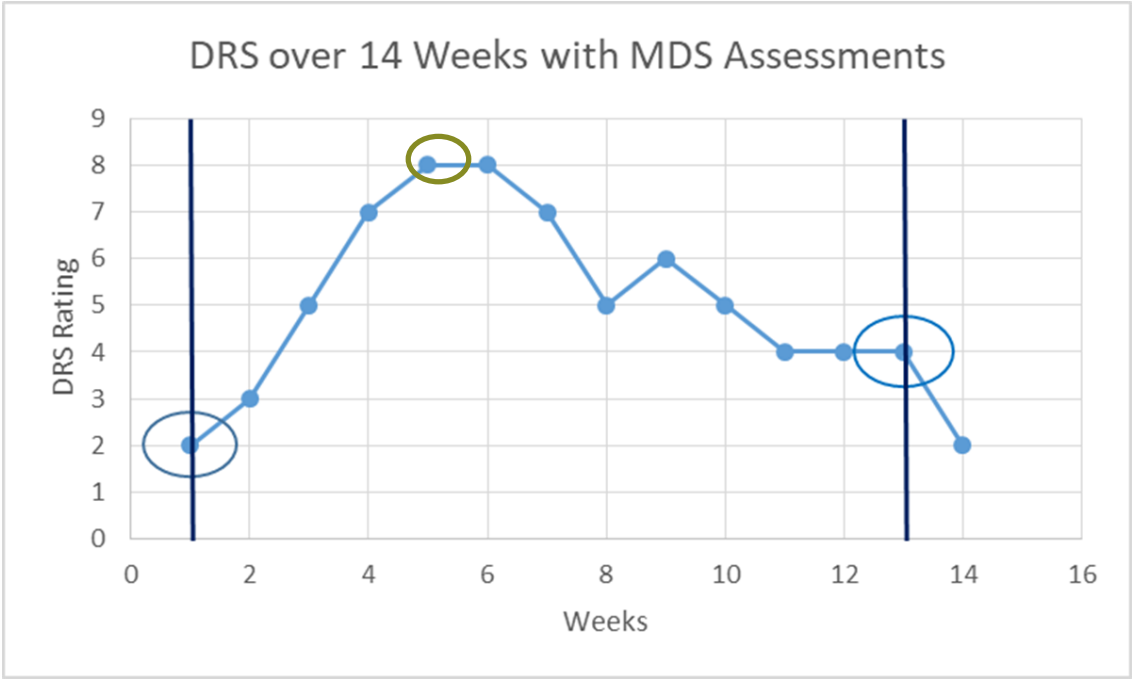
C:
- Possible triggers?
- Unmet care needs
  (e.g. Comfort rounds – Pain, Positioning, Personal needs, Toileting)
- Staff response?
- Interventions?
- Patient response?
- Plan?

#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***



#9 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

Graphic Resources

- Celebrate exemplary sites
- Model effective quality improvement
- Demonstrate the way forward
- Support engagement

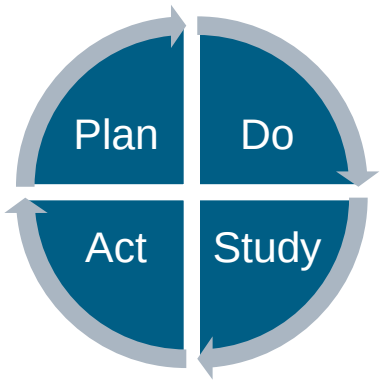
What are participants learning?

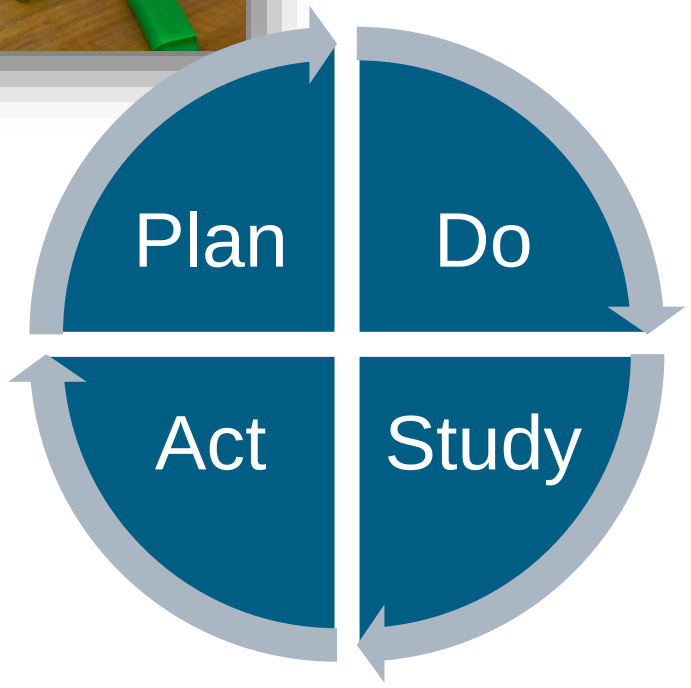
- Assessment, treatment & supportive strategies: Pain & DRS
- Appropriate prescribing & medication optimization
- Person-centered care planning process: Identify gaps e.g.
  - ✓ 1.2 Does the care plan reflect the assessment?
  - ✓ 1.3 IDT assessment to address physical, mental, emotional, intellectual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

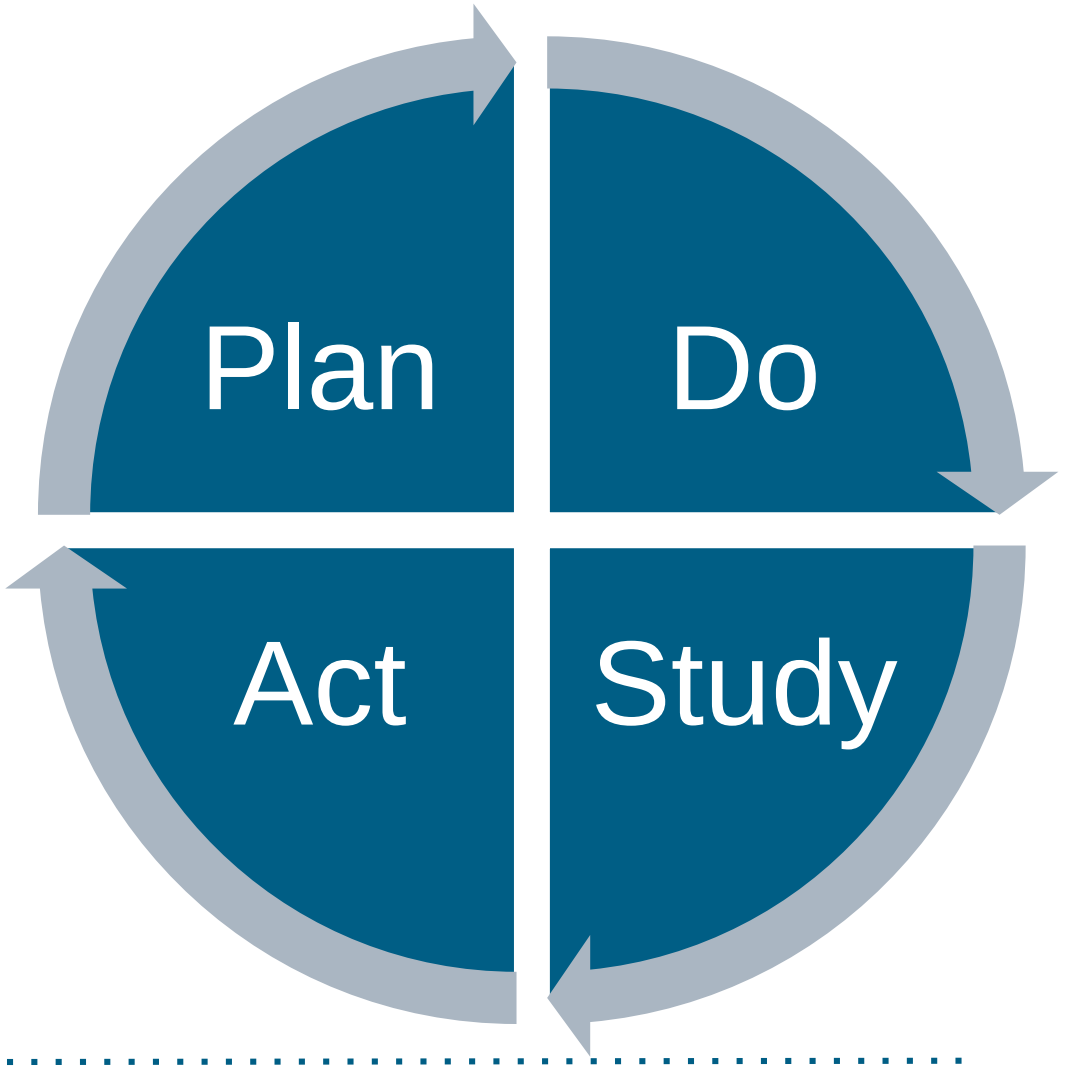
Team Action Planning

Plan to improve pain and mood with new ideas!

Team Action Planning



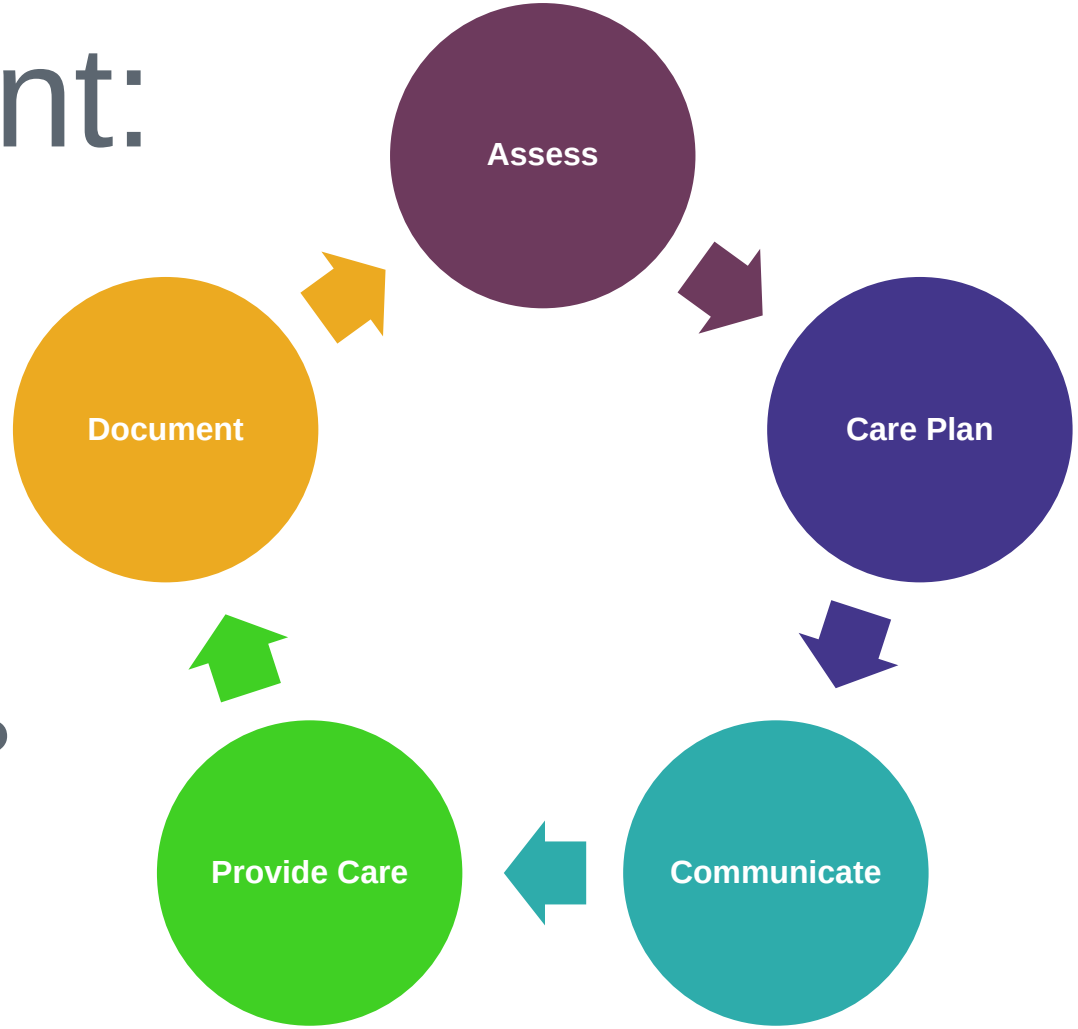




Quality Improvement:

Resident Comfort & Mood

- Residents triggering
  - DRS or pain
- Coding *a*ccurate?
- 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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